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Responsibility and resistance

**Children and young people's accounts of smoking in the
home and car**

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Abstract

Following the implementation of the smokefree law in 2006, which formed part of the Smoking, Health and Social Care (Scotland) Act 2005, smoking in enclosed public spaces has been prohibited in Scotland. The law has led to a number of improvements in public health but does not cover homes and cars where children are primarily exposed. Secondhand smoke (SHS) exposure is associated with particularly significant risks to child health, yet few studies have explored children's perspectives on SHS and smoking in the home and car. Comprising a qualitative exploration of the views and experiences of 38, 10- to 15-year-olds of SHS in the home and car, this thesis begins to address this gap. It addresses the nature and extent of children's involvement in negotiating smoking restrictions, compares the understandings, experiences and involvement among participants living in communities of contrasting socioeconomic profiles and considers the implications for health promotion interventions aimed at reducing children's exposure to SHS in the home and car.

Informed by a Childhood Studies perspective, the study focuses, both in methods and content, on the voices and agency of the participants. Recruited from two Edinburgh communities with contrasting socioeconomic profiles, the participants were interviewed either individually, in pairs or in small focus groups about their understandings of SHS, smoking restrictions in their homes and cars and their role in negotiating them. Home floor plans constructed by the participants were used to prompt discussion and also served to identify spatial and temporal home smoking restrictions. Both discursive and thematic techniques were used in analysis.

The thesis details the participants' overt and covert strategies to resist family members' smoking, demonstrating the active roles that participants describe in their accounts. While acknowledging SHS as a health risk and using an embodied language of disgust to describe it, the participants' main concern was for their

smoking family members' health, rather than their own. Many participants also challenged the stigma surrounding smoking parents by detailing the ways in which their parents restricted where, how much and with whom they smoked. Parents were described as especially careful in protecting small children from SHS. While most participants described such protective practices, those from the disadvantaged area reported less stringent smoking restrictions that were more challenging to negotiate.

Participants' resistant (to smoking) and defensive (of parents who smoke) accounts may stem from the growing stigma associated with smoking, particularly smoking in the presence of children. Such findings highlight the importance of a sensitive and asset based public health response that acknowledges parents' attempts to protect their children from SHS and recognises the potential of the active role of children in family negotiations around smoking in the home and car.

Declaration

I, Neneh Rowa-Dewar, declare that the following thesis has been composed by me and has not been submitted for any other degree or professional qualification.

Neneh Rowa-Dewar

.....

Date

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Chapter 1: Introduction

1.1 Secondhand smoke and child health

At 6am on March the 26th, 2006, smoking in enclosed public places and places of work became illegal in Scotland. Smokefree legislation followed in Wales and Northern Ireland in April 2007 and England in July 2007 and marked a change in the way smoking is viewed. Chief among the issues that made such an unprecedented policy step possible was the mounting evidence of the deleterious effects of secondhand smoke (SHS) exposure on public health. SHS refers to a mixture of the smoke given off by the burning end of a cigarette, pipe, or cigar (sidestream smoke), and the smoke exhaled by smokers (exhaled mainstream smoke). There has been a significant shift in the way SHS is perceived in the last few decades, illustrated in the difference between a World Health Organisation (WHO) report in 1971 stating that any deleterious health effects of smoking was “*largely confined to the individual smoker*” in the 1970s (1971:5-6) and the US Surgeon General Report in 2006 identifying SHS as “*a serious health hazard that can lead to disease and premature death in children and non-smoking adults*” (2006:3). Numerous tobacco control activities, including smoking prevention and cessation campaigns, restrictions on advertising, taxation and price increases, and provision of services to support people who smoke to quit, have resulted in 99 % of the UK population being able to identify at least one health risk of smoking and nearly 90 % being able to identify one or more adverse effects of SHS in 2010 (Wardle, Pickup, Lee, Hall, Pickering, Grieg, Moodie, and MacKintosh, 2010).

In a parallel shift, smoking has declined significantly across all socioeconomic groups since the 1970s. This decline in smoking prevalence has been particularly pronounced within socioeconomically advantaged groups. Consequently, smoking prevalence now follows “*the contours of social disadvantage*” (Graham, 1995:510). Smoking prevalence in Scotland’s most socioeconomically disadvantaged communities are currently at 43%, more similar to those of the general population in the 1970s than they are to the current 9% smoking prevalence rate in the most

socioeconomically advantaged communities (Scottish Health Survey, 2011). Those living in disadvantaged areas and circumstances are also inclined to smoke more than their advantaged counterparts (Johansson, Halling and Hermansson, 2003, Kaneita et al, 2006, Siapush, Heller and Singh, 2005). Further, the association between socioeconomic disadvantage and smoking persists throughout the life course; from parental smoking through to initiation, the move to regular smoking and heavy smoking in adulthood with lower quit rates (Jarvis and Wardle, 1999). Consequently, smoking is a key mechanism through which “health inequalities” – the gap between the morbidity and mortality of those at the top of the socioeconomic hierarchy and those at the bottom – are perpetuated in the UK (Jarvis, 1997, Marmot and Wilkinson, 1999).

Closing the gap in smoking-related morbidity and mortality between the classes has been high on the political agenda for several decades. The first White Paper on smoking, *Smoking Kills*, stated this explicitly: “*If we are to reduce smoking overall, and reduce health inequalities, we must start with the groups who smoke the most*” (The Stationary Office, 1998:4.20). Subsequent policy papers such as *Choosing Health* (Secretary of State for Health, 2004), the *Equally Well* report of the Scottish Government’s Ministerial Task Force on Health Inequalities (Scottish Government, 2008) and the *Tobacco Control Strategy for Scotland* (Scottish Government, 2012), all reiterate the importance of reducing smoking in the most disadvantaged groups to address health inequalities.

A raft of recent studies demonstrate the many positive public health consequences of the Scottish smokefree legislation, including a reduction of SHS exposure in adults (Haw and Gruer, 2007), in hospital admissions for acute coronary syndrome (Pell, Haw, Cobbe, Newby and Pell, 2008) and asthma in children (Mackay, Haw, Ayres, Fischbacher and Pell, 2010) and a reduction of SHS exposure for children living in non-smoking homes (Akthar, Currie, Currie and Haw, 2007). Despite these successes, the smokefree legislation does not include homes and cars where children whose family members smoke are most likely to be exposed to secondhand smoke. With their smaller airways, faster rates of breathing and immature immune systems, children are more susceptible and therefore vulnerable to the short and long-term

adverse health effects of SHS exposure (Bearer, 1995, Cook and Strachan, 1999, Muller, 2007). Children spend more time in the home in close proximity to their carers (Ferrence and Ashley, 2000) and have less control over their environment and are also less able to move away from SHS (Robinson and Kirkcaldy, 2007a). Childhood SHS exposure is associated with a range of illnesses ranging from common childhood illnesses, such as middle ear disease and lower respiratory tract infection, to increasing the severity of asthma and bacterial meningitis (Royal College of Physicians, 2010). Even more seriously, SHS exposure has also been shown to increase rates of Sudden Infant Death Syndrome (SIDS) (SCOTH, 2004) and lung cancer in adulthood with children exposed to SHS on a daily basis having three times the risk of lung cancer than those who grow up in smokefree homes (Vineis et al, 2005). In a recent review of the evidence on SHS and its impact on child health, The Royal College of Physicians (RCP) estimates that SHS exposure of children in the UK causes around 40 sudden infant deaths, over 20,000 cases of lower respiratory tract infection, 120,000 cases of middle ear diseases, at least 22,000 new cases of wheeze and asthma, and 200 cases of bacterial meningitis each year (RCP, 2010). Poor performance at school and other behavioural issues have also been associated with SHS exposure (Eskenazi and Castorina, 1999).

Globally, 40% of children are exposed to SHS in the home (Oberg, Jaakkola, Woodward, Peruga and Pruss-Ustun, 2011). In 2007, a year after the smokefree legislation was implemented, 27.4% of a representative sample of 11-year-old children in Scotland reported they were exposed to SHS in the home and 40% reported that they live with a parent who smokes (Akthar et al, 2007). Those living in socioeconomically disadvantaged areas are exposed to significantly more smoking in the home because of higher smoking rates (Akthar et al 2009, Bolte and Fromme 2009) and less stringent home smoking restrictions (Phillips et al, 2007). While the smokefree legislation appears to have reduced children's SHS exposure in disadvantaged areas, it was still higher than that of children from advantaged areas, suggesting that health inequalities are not only present but set to increase (Akthar et al, 2009).

Despite being the main site of SHS exposure for children, homes are likely to remain

exempt from tobacco control legislation. Constituting one of the last frontiers of tobacco control, homes represent a challenge for tobacco control and the Government. Legislation appears unlikely due to a presumed lack of public support and difficulty of enforcement (RCP, 2010). Furthermore, 'home' is not just a physical structure but a significant social concept encompassing social relations with wide symbolic and ideological meanings; feelings of belonging. Essentially, the spaces and symbolism of home are central to the construction of people's identities (Blunt and Dowling, 2006) and intervening legally into such a space may be fraught with challenges.

Instead, the aim to reduce children's exposure to SHS in the home and car has prompted evocative SHS health education campaigns featuring images of babies surrounded by parents' smoke and warnings on cigarette packets spell out the impact of smoking on the health of others. Recently, Professor Dame Sally Davies, England's Chief Medical Officer, stated that: "*Parents who smoke need to think about the effect it has on their family*" (BBC News, 31/3/2012). Interventions often focus on parents who smoke, particularly mothers, as children generally spend the most time in their proximity. Indeed, negative media stories regularly occur accompanied by paparazzi pictures of celebrity mothers, such as Billie Piper, Kate Garraway and Stacey Solomon, smoking when pregnant or near their children illustrating the *moral* aspect of SHS exposure of children. Morality encompasses any way that individuals form understandings of which practices are better than others and what we should believe, feel, and do. There are shared understandings of social worlds in moral terms, orienting individuals' lives, relationships, and activities around socially-produced notions of right and wrong (Hitlin and Vaisey, 2010).

Within the tobacco control field, researchers also express strong views on SHS exposure of children using moral arguments as exemplified recently by statements in a conference presentation by Dr Behrakis, when presenting his study on the constriction of airways due to SHS exposure (Behrakis, 2012): "*Second-hand smoking is the most widespread form of violence exerted on children and workers on a global level. The whole issue needs to be recognised as a global problem of human rights violation.*" (as reported by 23/10/2012 *The Daily Mail*).

While the lay public is not a passive recipient of “official” health education – but both shape and, at times, oppose it – such discourses set the parameters for available understandings of health issues as noted by Joffe (1999). In this context, the term ‘lay’ refers to non-expert individuals with no formal training in the relevant area, as opposed to experts, although this is not a clear distinction, some argue, because of the experiential knowledge that so-called lay people may have (see Prior, 2003, for a discussion). In the last few decades the boundaries of smoking have been redrawn with a new set of consequences, particularly for children, and new responsibilities, particularly for parents, emerging. Increasingly, understandings of smoking, particularly where others are perceived to be at risk as with SHS, have an increasingly moral dimension. In the most pointed sense, the official SHS narrative implies that children are the victims of irresponsible or, at least, ignorant smoking parents.

While the body of SHS evidence confirms the significance of the risk to child health that SHS poses, it is often of an epidemiological nature and/or derived by parents’ proxy reports. With some important exceptions (Michell, 1989ab, 1990, Woods, Springett, Porcellato, and Dugdill, 2005), there is a dearth of studies that explore child perspectives of SHS and smoking in the home and car. Hearing and listening to the voices of children has become a *“powerful and pervasive mantra for activists and policy makers worldwide”* (James, 2007), a mantra recited by politicians, health care professionals and academics alike following the ratification of Article 12 of the UN Convention on the Rights of the Child (UNCRC, 1989) which states that children have a right to be heard in all matters that concern them. Despite the powerful symbolic rhetoric of “children’s voices”, children may still find their voices silenced or ignored in their everyday lives, however, with few of the organisations that consult with children making actual changes based on such consultation (Morgan, 2005). Recognition of children’s views and experiences therefore remains ironically sporadic given the UNCRC commitment to children’s participation worldwide (James, 2007).

As mentioned, there are two important exceptions to the epidemiological/proxy rule in most SHS research which use innovative methodologies and explore children and

young people's own views and experiences of SHS (Michell, 1989ab, 1990, Woods et al, 2005). Together, they demonstrate that SHS is a cause for concern and deeply disliked for many child participants. However, these studies were conducted over one or two decades ago respectively, before the implementation of smokefree laws and many associated normative changes in how smoking and SHS is perceived. Larger studies mainly based on questionnaires, such as these, also inevitably sacrifice some detail and meaning that a smaller, qualitative, in-depth study such as the one described in this thesis may be better positioned to offer. Albeit from adult perspectives, other qualitative studies have shown the added value of explaining some of the social processes involved in smoking in the home (for example Poland, Gastaldo, Pancham, and Ferrence, 2009, Robinson, Ritchie, Amos, Greaves and Cunningham-Burley, 2012). Children's perspectives would contribute a largely missing perspective of such family negotiations; perspectives that can re-examine and perhaps even challenge taken for granted assumptions about children's roles in smoking in the home and car. The research presented within this thesis contributes perspectives from child participants and draws on the innovative methods and the qualitative dimension of previous studies within smoking in the home and car.

1.2. Research questions

This study is informed by Childhood Studies¹, a perspective that attends to the meaning and experience of being a child. It underlines children's active social roles and agency by unraveling the assumptions imbedded in much research, policy and practice of children as objects of study and concern.

The following statements articulate the research aims of this interpretative PhD study in the form of research questions:

1. What are 10- to 15-year-old children and young people's accounts of their understandings and experiences of SHS in the home and car?

¹ Childhood Studies is generally capitalised to differentiate this perspective from other studies of childhood with a different ontological and epistemological approach.

2. What is the nature and extent of their involvement in decisions around negotiating smoking restrictions in the home and car according to them?
3. How do understandings, experiences and involvement contrast among children living in communities of contrasting socioeconomic profiles?
4. What are the implications for health promotion interventions aimed at reducing children's exposure to SHS in the home and car?

This work is situated within an interdisciplinary public health. Following an interpretivist tradition of social science research this study is not examining why people *do not* protect children but instead, the ways in which children are protected and indeed, how they are attempting to protect themselves. The benefits of this orientation are clear to public health practice as, without an empathetic understanding of why people behave as they do and what they are already doing to protect others and themselves from SHS exposure, we are unlikely to identify the possibilities for change.

Recently, stigma as a consequence of tobacco control initiatives such as smokefree laws and the ethics of the deliberate use of them to serve public health purposes has been debated (Bayer, 2008, Bell, Salmon, Bowers, Bell and McCullough, 2010, Graham, 2012). As the first qualitative study of its kind to explore 10- to 15-year-old children and young people's views and experiences of second hand smoke, this thesis will contribute a seldom heard child's perspective of SHS exposure to the field of SHS research in general and this debate in particular. As such it has clear implications for health education and promotion practice, research and policy regarding SHS.

A note on terms

When writing and speaking about the participants of this study to academic, practitioner and policy audiences, using "children and young people" throughout the

thesis and presentations appears cumbersome. While being under 16 years of age, participants may legally be classified as children, yet referring to older participant as children could be considered condescending. Equally, referring to 10-year-olds as young people may conjure up an image of teenagers. To solve this dilemma, I asked the first few participants in my study, who were 13, 14 and 15 years old respectively, which term they preferred and they suggested “teenagers” initially but changed their minds to “children” when I informed them that some of the participants would be younger than 13. When collectively referring to the children and young people who participated in this study I will therefore use the term “participants” or “children” and the term “children” when referring to SHS and methodological literature or making wider recommendations, as that is the term generally used by other authors.

1.3. Structure of the Thesis

Having introduced the primary concerns of this thesis, *Chapter 2* will proceed to critically appraise the evidence base of SHS and smoking in the home and car and provide a review of relevant theories of risk. While the evidence is wide in scope and establishes the risk SHS poses to child health, several important aspects remain little explored, particularly children and young people’s views, experiences and perspectives on SHS risk. However, evidence from other qualitative studies of smoking in the home contributes to our understanding of social processes and interactions that underscore dimensions of power likely to be pertinent to this study.

In *Chapter 3*, the perspective of Childhood Studies will be detailed and critically examined. It has become *the* approach to framing and studying children and young people’s perspectives, yet, several of its central tenets have been critiqued of late with implications for research with children such as those included in this study.

While methodological issues will be discussed as part of all three data chapters, *Chapter 4* provides a detailed description and discussion of the methodological approach and methods employed over the course of this research. It provides reflections on the research process within an approximately chronological account of the preparation, recruitment of participants, methods, data collection and the process

of analysis.

As the first of three chapters attending to the findings from interviews and focus groups with the children and young people who participated in the study, *Chapter 5* attends to participant understandings of SHS and the risk it may involve, under what circumstances and for whom. It demonstrates that while SHS is disliked and the risk is not contested, it is not detailed or personalised in most accounts. To make sense of SHS risk, participants draw on the more familiar discourse of smoking risk and also consider certain vulnerable groups more at risk.

In *Chapter 6*, the participants' accounts of their family members' smoking practices in the home and car are discussed. Accounts of smoking restrictions illustrate how many participants frame their parents as engaging in responsible smoking practices. Parents are in control of how much, where, when and in the presence of whom they smoke to ensure others are not affected by SHS. Most accounts analysed in this chapter were prompted by the construction of home floor plans and these are used to illustrate some of the data.

The framing of children as passive in much SHS literature is challenged in analysis of participants' accounts of their practices of resistance to their family members' smoking in *Chapter 7*. Most provided examples of resistant words and deeds intended to reduce or stop their parents smoking. These ranged from the overt and sometimes confrontational, to the covert strategies practised, such as hiding and breaking cigarettes to the forming of alliances with younger siblings. Many participants did not engage in words and deeds of resistance and such accounts are also examined. Similarly to the preceding two chapters, this chapter therefore also discusses accounts that deviate from others.

Lastly, *Chapter 8* brings together the empirical and conceptual strands of the thesis and connects them to previous research to render the contribution of the thesis more explicit. It discusses the ways in which the interlinked themes of risk, morality and responsibility are underscored by the themes of agency and morality in the participants' accounts. The implications of these findings for future research are

discussed and the chapter concludes with the implications of the thesis findings for policy and practice relating to reducing children and young people's SHS exposure in the home and car. It suggests that a deficit approach of identifying and informing parents and children about the risks of SHS exposure in the home and car should be accompanied by an assets approach. Such an approach would recognise the potential of parents' protective practices and in children's active roles.

Chapter 2: Literature review

2.1. Introduction

This chapter provides a background to, and critical review of, SHS and smoking in the home and car research, policy and practice. It begins with an overview of how SHS became an issue of public health and policy concern. It proceeds to detail and discuss previous work undertaken within the SHS field and smoking in the home and car, including studies that investigate the effect of smokefree laws and those that examine smoking restrictions in private settings. The chapter then turns to an examination of the limited number of studies that have explored children and young people's perspectives on SHS to date and concludes with a review of theories of risk. Throughout the chapter, themes of inequality, risk and morality in the literature are highlighted as they are pertinent to the narrative of SHS and this thesis.

The identification of relevant literature for the review has been an ongoing and iterative process. In the preliminary stages, searches of literature relating to children and SHS health risk were undertaken using MedLine, Psychinfo, ASSIA, EMBASE and the Cochrane Database of systematic reviews: a search which has been continually updated as new findings emerge. Given the range of terms used to describe both SHS and children, I employed a broad search strategy by combining the search terms SHS/passive smoke/ETS/ambient/ involuntary smoke with children/babies/infants and/or young people/adolescents/teenagers. The searches were limited to English language, though no restrictions were placed on the date of publication. Initial searches in my first year of study quickly demonstrated the scarcity of work on smoking in the home from a social science perspective, particularly research with child participants, and while this literature has developed and provided added insight into the field, it remains limited. As I began to gather data and progressed with the analysis, further literature searches were undertaken based on themes emerging from the ongoing research process, for example, moral accounts, child agency and the methodological perspective of Childhood Studies that

has informed this thesis (as reviewed in Chapter 3).

2.2. SHS and child health

Early SHS studies examined the health risk posed to wives and children of men who smoked (Hirayama, 1981). With growing evidence that children are at higher risk of SHS, in the 1990s and 2000s the focus changed to, and has remained with, children and the risk SHS poses to their health. Children are at significantly greater risk from SHS exposure than adults because of their higher respiratory rates, less well-developed airways, lungs and immune system (Bearer, 1995, Willers, Skarping, Dalene, and Skerfving, 1995, Muller, 2007). Children also spend more time in the home in close proximity to their carers (Ferrence and Ashley, 2000). Because children usually spend more time in close physical contact with their mothers, maternal smoking practices are more predictive of SHS exposure than paternal practices, leading to prolonged pre- and post-natal exposure if women smoke. Children, especially younger children, are less in control of their environment than adults and less able to move away from SHS (Robinson and Kirkcaldy, 2007). And, irrespective of SHS exposure, evidence that children with smoking parents are more likely to become smokers themselves is well established (Doherty and Allen, 1994), probably attributable to role-modeling.

A wide range of associations between ill health and SHS exposure have now been found with a string of systematic reviews establishing the significant risk of SHS to child health. In the 1990s, Cook, Strachan and Anderson published a series of definitive systematic reviews and meta-analyses (1999). Revised versions of these reviews also provided estimated effects of SHS on child health for the Scientific Committee of Tobacco and Health report (2004) which, in turn, with the extension of literature searches to 2001, formed the basis of the analyses presented in the US Surgeon General's report on involuntary exposure to tobacco smoke (2006). Most recently, the Royal College of Physicians (RCP) report *Passive smoking and children* updated the systematic reviews and meta-analyses of SHS effects to provide contemporary best estimates based on 75 comparative epidemiological studies published in English (2010). Together, these reviews have established causal

associations between SHS exposure in childhood and higher incidence of SIDS (SCOTH, 2004), bacterial meningitis, lower respiratory tract infection, impairment of lung function, middle ear disease and asthma in school-aged children (RCP, 2010). Those exposed to SHS in childhood have been found to have three times the risk of developing lung cancer in adulthood than those who grow up in smokefree homes (Vineis, 2005). SHS exposure is estimated to cause around 40 sudden infant deaths, over 20,000 cases of lower respiratory tract infection, 120,000 cases of middle ear diseases, at least 22,000 new cases of wheeze and asthma, and 200 cases of bacterial meningitis each year (RCP, 2010). School performance, perhaps because of more incidence of illness leading to absence, and other behavioural issues have also been associated with SHS exposure (Eskenazi and Castorina, 1999).

Recently an association between SHS exposure and mental health has been uncovered. Using data from the 2003 Scottish Health Survey with a sample of 901 non-smoking children between the ages of 4 and 12 years, Hamer and his colleagues measured salivary cotinine levels and responses to The Strengths and Difficulties Questionnaire (SDQ), which measures psychological distress (Hamer, Ford, Stamatakis, Dockray and Batty, 2011). Cotinine is a metabolite of nicotine with a longer half-life than nicotine, detected in bodily fluids such as saliva and used as a biomarker to assess exposure to tobacco/tobacco smoke (Collier, Goldstein, Shrewsbury, Davis and Koch 1994). Children in the “high SHS exposure” quartile had significantly higher total SDQ scores, particularly on hyperactivity and conduct disorder, compared with those in the low quartile, demonstrating a dose-response effect across the sample.

Similar evidence of a significant association between higher SHS exposure and mental health disorders comes from a recent US study where the association between SHS exposure and mental health symptoms symptoms was explored in a sample of children and adolescents aged 8 -15 years (Bandiera, Kalaydjian Richardson, Lee, He and Merikangas, 2011) and, unlike in Hamer et al’s study (2011), adjustments were made for maternal smoking during pregnancy. Bandiera et al (2011) is the only study that attempts to allow for stress by controlling “allostatic load”, which represents the “wear and tear of the body’s response to prolonged psychological

stress” (2011:332) yet controlling for allostatic load did not weaken the associations between cotinine levels and mental health symptoms, adding uncertainty about allostatic load as an underlying causality of psychological stress (2011:336).

This emerging field points to SHS having more than the many established physical effects. However, it is both limited and has a number of limitations (Samet, 2011). A key limitation is that the association between SHS, socioeconomic disadvantage and mental health disorders may mean SHS is simply a proxy for more stressful living conditions. Indeed, children with higher cotinine levels in these studies were more likely to live in areas of greater socioeconomic disadvantage.

A year after the smokefree legislation was implemented in Scotland, 40% of a representative sample of 11-year-old children reported that they live with a parent who smokes, 27.4% reported that they were exposed to SHS in the home, 9.5 % that they were exposed in someone else’s home and 6.5% that they were exposed to SHS in the car (Akthar, Currie, Currie and Haw, 2007). Children living in socioeconomically disadvantaged circumstances are more likely to be exposed to SHS (Akthar, Haw, Currie, Zachary and Currie 2009, Bolte and Fromme, 2009) and disadvantaged homes are less likely to have stringent smoking restrictions (Phillips et al, 2007). Consequently, there are significant health inequalities in children’s SHS exposure. In the UK, 54% of babies and young children from the least advantaged backgrounds are regularly exposed to SHS in the home, compared with 18% from families with a professional background (RCP, 2010). While the smokefree legislation appears to have reduced children’s SHS exposure in disadvantaged areas, it was still higher than that of children from advantaged areas, suggesting that health inequalities are not only present but are set to increase (Akthar et al, 2009).

Despite the large and developing evidence base of the association between SHS and physical health of children exposed, gaps remain in our understanding. The majority of studies have been conducted with very young children, hence the effect of SHS exposure on older children is not known. Neither is the dose-response relationship between SHS exposure and ill health leading to an erring on the side of caution with the advocating of a “no safe level of SHS exposure” message (RCP, 2010). Kirsten

Bell and colleagues (2010) have critiqued this message, pointing to emerging evidence of such a relationship in an Italian case-control study (Fantuzzi, Aggazzotti, Righi, Facchinetti, Bertucci, E., Kanitz, et al, 2007) that demonstrated a relationship between preterm/early preterm delivery and active smoking as well as SHS exposure in a sample of pregnant women. Fantuzzi et al assessed active smoking and SHS exposure using a questionnaire and found SHS exposure to be associated with early preterm delivery, with a dose-response relationship with the number of smokers in the home. While these findings are interesting and warrant further studies, it is too early to suggest that such studies imply that the “no safe level of SHS” message should change.

While gaps remain in this literature – particularly in relation to the underlying causation, the magnitude of the risk and the age at which children are less at risk – the many deleterious health effects on child health associated with SHS exposure outlined in this section have made it an increasingly significant area for public health policy as the next section will detail.

2.3. Policy context

Governmental public health campaigns, legislation and cessation programmes have been instrumental in bringing SHS to the attention of the public and also, importantly, have set the tone of debates in scientific and lay representation of risk as they represent a “*central, official position which crystallises what has been deemed a desirable message in the public health policy realm*” (Joffe, 1999:51). Tobacco companies and their marketing and lobbying tactics also attempt to affect how smoking and SHS are represented to challenge tobacco control measures. Drawing on an individual rights discourse they emphasise that individuals have the right to decide if, and where, they should smoke and challenge tobacco control measures such as display bans and plain packaging based on this notion. The relationship between the tobacco control community and tobacco companies is one characterised by conflict and, at times, hostility. Tobacco companies challenge tobacco control measures and the tobacco control community aim to reveal and publicise the marketing tactics and issues surrounding production in addition to the morbidity and

mortality caused by tobacco use.

Acknowledgement of the health risks smoking entails has made it a constant feature on policy agendas since the 1960s, but SHS as a health risk has been a relatively recent addition. Until the last quarter of the 20th century, the debate on the effect smoking had on others focused on smell and aesthetics rather than any health risk it might pose (Tinkler, 2006, Hilton, 2000). It was during this time that tobacco companies began to attempt to counteract the “smelly smoker” image by focusing on the “considerate smoker” who protected others from their smoke by voluntary measures (Tinkler, 2006). Indeed, as mentioned in Chapter 1, as recently as the early 1970s, the WHO position on SHS was that: *“The health effects of smoking are largely confined to the individual smoker and, although severe, become manifest only after many years of smoking”* (WHO, 1971:5-6). It was not until the mid- to late 1980s that emerging evidence of an association between long term exposure to SHS and ill health began to shift public health discourse, as can be seen in Peto and Doll’s rebuttal of public and media doubts around the connection of ill health and SHS (here referred to as “ambient smoke”):

It is now generally accepted that a safe threshold is unlikely to exist for most carcinogens ...exposure to ambient smoke must be assumed to cause some lung cancers in non-smokers. (1986:381)

The tentative manner in which the risk associated with SHS was described, “must be assumed”, “some” and “unlikely”, belies the medical legitimacy provided by evidence published some years earlier. Evidence that SHS exposure (secondhand smoke exposure) can result in serious illness or even death among non-smokers living with people who smoke first appeared in the Lancet, in 1974 (Harlap and Davies, 1974). In 1981, a large-scale study by the Japanese epidemiologist Hirayama was published in the BMJ, demonstrating that non-smoking wives of men who smoked heavily had an increased risk of lung cancer (Hirayama, 1981). Following these and other studies in the most internationally influential review on SHS effects on health, the US Surgeon General Report, (1986) concluded that passive smoking caused serious diseases such as lung cancer in non-smokers. SHS has since been declared a Group A Carcinogen – a directly cancer-causing agent in humans – by the

U.S. Environmental Protection Agency (EPA, 1992) and the International Agency for Research on Cancer (IARC, 2004).

The idea of a smokefree law for enclosed public places has been widely discussed in the Cabinet and governmental committees and within the RCP since the 1960s and '70s. Concerns about the public acceptance of such a measure has long presented an obstacle to an implementation strategy and informing the public about the risks of smoking while allowing free choice to smoke has long been considered the best option. Emerging evidence of two kinds challenged this notion, however. First, smoking, as an addiction, limits free choice. Second, through SHS, smoking affects those who do not smoke.

While the exact process towards smokefree laws in the UK is contested (see Berridge, 2007, Donnelly and Whittle, 2008, for different accounts), commentators agree that a change in public perceptions of smoking and SHS have been a key factor in the successful implementation of tobacco control measures. Media campaigns using broadcast and the print media at the time of the implementation of the smokefree law in Scotland featuring images of children surrounded by clouds of smoke (in one case a baby in a car seat with smoke forming a noose around its neck) such imagery was arguably intended to induce (parental) guilt and may have a part to play in a change of public perception towards SHS and other individuals smoking near to children.

However, the assumptions underpinning health education promotional campaigns delivered via large audience media designed to induce guilt and/or fear have been critiqued. Rotfeld suggests there is a slippage between the idea that mass media campaigns can promote products and stimulate consumption and the idea that they can modify or reduce undesirable health behaviours, because consumption and self-denial are at odds with each other (2002:466). Campaigns may be harmful rather than helpful as they risk stimulating defensiveness in challenging behaviours difficult to change (Hastings, Stead and Webb, 2004). Despite such critique, recent data suggest they have been effective in increasing awareness of SHS. According to survey data, 99% of the adult UK population can identify at least one health risk of

smoking and nearly 90% can identify a health risk associated with SHS exposure (Wardle et al, 2010). Several commentators have also suggested that the process towards increasingly strict tobacco control has been aided, even prompted, by the association between smoking and lower socioeconomic status (Bell et al, 2010, Graham, 2012), as further discussed later in this chapter.

Global tobacco control policy advanced significantly in 2003 when the World Health Organization (WHO) ratified its first international public health Treaty: the Framework Convention on Tobacco Control (FCTC) (WHO, 2003). Adopted by 174 countries to date, the most debated part of the FCTC is Article 8: “Protection from exposure to tobacco smoke” that sets out recommendations for national, comprehensive smokefree legislation. The first law of this type was introduced in Ireland in 2004, followed by Norway and New Zealand, the process and experience of which served to inform Article 8. Similar legislation has now been introduced in many other countries, including Scotland where a political consensus accompanied the publication and passage of the Smoking, Health and Social Care (Scotland) Bill (2005) by the Scottish Parliament, including legislation against smoking in enclosed public places as recommended by the FCTC. On March the 26th in 2006, smoking in enclosed public places and places of work became illegal in Scotland with five exemptions from the legislation including specified workplaces, residential institutions, Crown bodies and property, diplomatic premises and private dwellings. While the main impetus for the smokefree legislation was to protect non-smokers from the harmful health effects of SHS exposure, it was also desired that smokefree public places would provide a supportive environment for people wanting to stop smoking by altering smoking norms and restricting places where smoking was visible or indeed, possible.

However, the smokefree legislation does not cover homes or cars – the main settings of SHS exposure for children (Ashley and Ferrence, 1998; Wipfli, Avila-Tang, Navas-Acien, Kim, Onicescu, Yuan, Breysse, and Samet, 2008). Smoking by parents and other carers such as grandparents and whether smoking is allowed in the home have been found to be the two main determinants of children’s SHS exposure (Sims et al, 2010). While legislation against smoking in the home is not considered

feasible (RCP, 2010, Pell and Haw, 2009), proposals to legislate against smoking in cars carrying children has widespread public support (Hitchman, Fong, Zanna, Hyland and Bansal-Travers, 2011, Thomson and Wilson, 2009) and the support of organisations such as RCP, ASH, The British Medical Association and the British Lung Foundation. There has recently been a parliamentary debate calling on legislation to ban smoking in cars containing children with a bill put forward by the Labour MP Alex Cunningham to outlaw smoking in cars carrying children, approved by the House of Lords but is still subject to hostility from all political parties. Currently, the Scottish Government does not intend to legislate against smoking in cars (Scottish Government, 2012).

In November 2011, the British Medical Association (BMA) called on legislation to prohibit smoking during all car journeys in the UK. The chapter now turns to the impressive impact of smokefree laws and other tobacco control measures, including the unintended and negative consequences of denormalisation strategies.

2.4 Intended and unintended consequences of smokefree legislation

The smokefree legislation in Scotland has been the subject of a comprehensive evaluation strategy to assess its impact on SHS exposure, respiratory and coronary diseases, social norms and on the leisure industry. Comprising studies by seven research teams from varying disciplines, including public health, social science, social marketing, physicians, biochemists, occupational medicine and tobacco control, the evaluation was coordinated by NHS Health Scotland (Haw, Gruer, Amos, Currie, Fischbacher, Fong et al, 2006).

Two years after the smokefree legislation was implemented in Scotland, a significant reduction in SHS exposure in public places was demonstrated (Haw and Gruer, 2007), particularly among workers in the hospitality industries (Semple, Maccalman, Naji, Dempsey, Hilton, Miller et al, 2007). The smokefree law has improved public health in a number of significant ways. Reductions have been observed in hospital admissions for coronary heart disease (Pell et al 2008), SHS exposure in the general population (Haw and Gruer, 2007), hospital admissions for childhood asthma

(Mackay et al, 2010) and preterm deliveries (Mackay, Nelson, Haw and Pell, 2012). Acceptance of the smokefree legislation in Scotland has been found to be high in the general population (Hyland, Hassan, Higbee, Bodreau, Fong and Borland, 2009) and environmental health officers estimated an impressive 97% rate of compliance two years post-implementation (as reported in Pell and Haw, 2009). The impact of smokefree legislation has thus been significant and public compliance and improvements to public health have been echoed throughout the rest of the UK (RCP, 2010, Callinan et al, 2010).

Such impressive effects may be due to the association between smokefree public places and an increase in cessation rates and lower levels of smoking, generally (Farrelly, Evans and Stefakas, 1999). For instance, a systematic review of 26 studies in the United States, Australia, Canada and Germany on the effects of smokefree workplaces found that smokefree workplace policies are associated with an approximate 4% reduction in smoking prevalence (Fichtenberg and Glantz, 2002). In the UK, smokefree legislation and other tobacco control activities such as tax increases, media campaigns, health warnings on cigarette-packs and cessation services have contributed to an overall reduction in smoking prevalence among adults, from 40% in 1978 to 21% in 2007 (Office for National Statistics, 2007). There is evidence of a marked decrease in adults' (who do not smoke) SHS exposure in homes year on year: from 18% in 1998 to 10% in 2008 for both sexes, exposure in other people's homes has also declined from 21% to 12% for men, and from 25% to 13% for women in the same period of time (Scottish Household Survey, 2008).

Although the primary objective of smokefree legislation is to protect the public from SHS, and ultimately, to improve health, smokefree laws can, and have, changed social norms around smoking and result in changes in smoking behaviour (Bauld, 2011). Qualitative evidence from Scotland (Martin et al, 2008, Ritchie et al, 2010) and England (Platt Amos, Godfrey, Martin, Ritchie, White et al, 2009, Hargreaves, Amos, Hight, Martin, Platt, Ritchie et al, 2010) demonstrates the normative impact of the legislation. Both these studies were longitudinal and conducted in four Scottish and six English areas of contrasting socioeconomic and rural/urban profiles. Comparative community studies of this kind assume that the social context of

smoking is an important factor in the shared smoking behaviours of a community (Dedobbeleer, Beland, Contandriopoulos and Adrian, 2004, Frohlich et al 2000).

Martin et al's 2008 study examined the process and impact of the Scottish smokefree legislation in four Scottish communities of contrasting socioeconomic and rural/urban profiles. The multi-method design included in-depth, interviews pre- and post-legislation with adults, professionals and repeat observations in a range of public places in each community. The interviews and observations explored perceptions of the legislation and compared changes over time in perceptions, attitudes and behaviour and also examined if the smokefree law impacted on population groups and communities differently.

Given two of the four communities examined in Martin et al's (2008) study are the same as the communities in my study, it warrants a closer examination. By examining changes in the social context of smokefree public places before and after the smokefree legislation, Martin and colleagues improved our understanding of the factors involved in the creation of smokefree environments (2008). Understandings of secondhand smoke (SHS) shifted over time. Prior to the smokefree law, SHS would be discussed in terms of its unpleasant smell, rather than as a risk to health with some participants resisting the idea, particularly in disadvantaged areas. However, many discussed smoking away from others, particularly children.

Participants who recognised the potentially harmful effects of SHS were not always clear on the mechanisms of exposure. There was a greater acceptance that SHS could affect the health of both children and adults negatively after smokefree legislation, rather than only the health of children as had been the case pre-legislation. Martin et al report that participants in the advantaged communities were generally better informed and accepting of the potential risk SHS poses compared to those in the disadvantaged areas who were more likely to "focus on visible signs of a smoky environment (not on its effect) and to underplay the health risks to others" (2008:32). This is a complex issue. Lack of knowledge of the risks of harm from SHS has been linked with lower child exposure (Lader, 2008), yet establishing and maintaining smoking restrictions involves more than risk awareness.

These large qualitative studies provide convincing and nuanced evidence of normative changes and community differences but have limitations. Both studies were limited by geography, the non-representative samples and self-reported changes in smoking behaviour. As acknowledged by the authors, pre-legislation data were collected in the months immediately leading up to the legislation, therefore changes may already have taken place in social norms resulting from the publicity about SHS and the law. Chapman and Freeman warn against only crediting smokefree laws with normative changes in smoking prevalence and practices, in saying that such changes are due to “*the synergistic influence across time of many formal interventions as well as a myriad of ‘uncounted’ cultural influences on the way that smoking is talked about in news and the entertainment media, in everyday conversation and on the Internet*” (2007:25).

Yet, restricting where smoking is permitted is a powerful message and denormalisation of smoking and smoking close to others is likely to have progressed more rapidly as a result, as demonstrated by numerous studies indicating a positive influence of the smokefree laws on child health. Where smokefree workplaces and enclosed public places are the norm, studies have indicated that parents are more likely to try and prevent smoking in the home (Borland, Mullins, Trotter and White, 1999; Soliman, Pollack and Warner, 2004).

A number of UK studies suggest that changes in social norms due to smokefree laws in enclosed public places have transferred to smoking in enclosed private spaces, albeit with a sharp socioeconomic gradient (Moore, Currie, Gilmore, Holliday and Moore, 2012). For example, there is evidence of a modest but significant reduction in the number of Irish homes allowing smoking post-smokefree legislation (Fong, 2006) and the percentage of Californian adults reporting smokefree homes a year post-smokefree legislation (Gilpin, Farkas, Emery, Ake and Pierce, 2002). Reductions in SHS exposure were also found for children in Scotland whose fathers smoked (Akhtar et al, 2007) and in Wales (Holliday, Moore and Moore, 2009). In an English study, SHS exposure of children aged 4 to 15 reduced by 70% between 1996 and 2007 (Sims et al, 2010, RCP, 2010). The greatest decline was in 2005 and 2006, preceding smokefree legislation, probably as a consequence of SHS media

campaigns broadcasted at that time.

Despite SHS exposure declining most in those most exposed at the outset – those living in households allowing smoking, with parents who smoked and in disadvantaged homes – inequalities still remained. Another related study using the same dataset found that the proportion of children living with two parents who smoke declined from 11% to 5% between 1996 and 2007 (Jarvis et al, 2009) and that child exposure to SHS had reduced since the legislation in England with no displacement effect into the home (Moore et al, 2012).

In Scotland, a recent study has demonstrated an 18.3 % reduction per year in the rate of hospital admissions for asthma amongst pre-school and school age children in Scotland compared to figures on the day of the smokefree law implementation (Mackay et al, 2012). However, a recent Cochrane review of 15 international studies found no change in exposure overall at home following the implementation of smokefree legislation, despite that three studies found that exposure levels in the home reduced (Callinan et al, 2010).

The most comprehensive study on the effect of the smokefree law in Scotland on children's health is the Scottish Child exposure to Environmental Tobacco Smoke (CHETS) study, a nation-wide Scottish study of 11-year-olds' cotinine levels pre- and post-legislation (Akthar et al 2007). Akthar and her colleagues surveyed 2559 children in January 2006 (pre-smokefree legislation) and 2424 in January 2007 (post-legislation) on parental smoking and exposure to SHS in public and private places, measured children's salivary cotinine concentrations, and found a 39% reduction. The proportion of primary school children reporting smokefree homes, as opposed to homes with a partial or no ban, also increased from 47% to 52% (independent of parental smoking status). However, this result varied among children according to how many adults in their home smoked and was statistically significant only among children who lived in homes where neither parent smoked (51% reduction) and for those living with only a smoking father (44% reduction). Cotinine levels fell by (a non-statistically significant) 11% among children who lived with two parents who smoked or only a mother who smoked.

Akhtar et al also found a reduction in reports of secondhand smoke exposure when visiting other people's homes post-legislation, a finding they interpreted as a change in smoking practices in front of non-family members after the legislation due to increased awareness of the health risks associated with SHS and to changing social norms (2007). It therefore appears that the smokefree legislation served to quickly reduce SHS exposure among children aged 11 in Scotland, without a displacement of more SHS exposure into homes. Yet children who benefited the most were those who already had either a low or no SHS exposure in their homes which led Akhtar et al to further analyse the latter group, concluding that there is an indication that the smokefree legislation has increased health inequalities amongst children (2009). Further details of this and the other CHETS studies and the limitations of them, will be discussed later in this chapter.

Studies showing the reduction in children's SHS exposure post-smokefree laws are important because they disprove one of the main concerns before the implementation of the smokefree laws in the UK. Prior to the implementation of the legislation, Dr John Reid, Minister for Health, raised the concern that a smokefree law may lead to a displacement effect, where less smoking in public places would increase smoking in the home and children's SHS exposure would therefore increase (Adda and Cornaglia, 2006). As mentioned, this appears to be an unfounded concern, indeed smoking in homes appears to have reduced post-legislation. Smoking in cars remains unchanged post-legislation (Akhtar et al, 2007, Fong 2006, Haw and Gruer, 2007). In a recent study, Semple et al (2012) have demonstrated that levels of SHS in cars equals those to be found in a smoky pubs pre-legislation and joins calls for legislation to protect child health from ASH, BMA, The House of Lords and others.

The emergence of SHS as a public health issue has resulted in unprecedented legislation concerning the use of tobacco. Such legislative measures have consequences, both intended and unintended. Amongst the policy advances and successes, an emerging discourse challenges the positive consequences of tobacco control measures by highlighting their potentially stigmatising effects (Bell et al, 2010, Graham, 2012, Ritchie et al 2010).

The fragrant has become foul; an emblem of attraction has become repulsive; a mark of sociability has become deviant; a public behaviour now is virtually private. (Brandt, 1998: 176)

With these lines, Brandt describes the change in how smoking has come to be perceived in the US at the end of the 1990s. Over a decade later this change is evident across Western countries, perhaps particularly because of increasing evidence of SHS affecting the health of others including “innocent children”. Social denormalisation of tobacco use, or in other words, seeking “*to push tobacco out of the charmed circle of normal desirable practice to being an abnormal practice*” (Hammond, Fong, Zanna, Thrasher and Borland, 2006:225), is an explicit aim of several tobacco control organisations and of smokefree policies which restrict where smoking is permitted and the selling and promoting of tobacco products and by informing the public of the risk that smoking and SHS pose to health including the most recent draft Tobacco Control Strategy for Scotland (2012).

Denormalisation strategies aim to make *smoking* rather than *smokers* unacceptable (Hammond et al, 2006), yet the two are often conflated in everyday discourse and media representations and the stigmatisation of people who smoke may be a consequence of both (Bayer and Stuber, 2008). The concept of stigma draws on Erving Goffman’s classic analysis (1963) of the “spoiled identity” of those stigmatised. Despite Goffman’s *Notes on Stigma* being written prior to much of the work around smoking, it has informed tobacco research for the past two decades. He highlighted experiences of the individual who “possesses a trait that can obtrude itself upon attention and turn those whom he meets away from him” (Goffman, 1963:15) and emphasised the socially produced element of stigma where a more powerful individual, agency or institution denigrate an individual or group who is relatively disadvantaged. In Link and Phelan’s words: “*stigma is entirely contingent on access to social, economic, and political power*” (Link and Phelan, 2001: 375). Here, the relevance of smoking prevalence in different classes is clear, and one, which Graham argues, has been referred to, but not truly engaged with, in much tobacco control debate to date (2012).

Stigma has long been associated with health behaviours considered reckless in everyday discourse, an everyday discourse which often refers to people as either “good” or “bad” depending on whether they avoid, minimise or engage with risky behaviours (Lawler, 2005). Depending on people’s responses to what is considered risky, boundaries are drawn between those perceived to be healthy, self-disciplined and therefore “good”, and those who are perceived to be unhealthy, lacking control of their own health behaviours and “bad” (Crawford, 1977, Petersen and Lupton, 1996).

Crawford posits that health is a primary value, particularly for the middle classes. Health symbolises other Western values linked to the Protestant work ethic, namely being “in control” and possessing self-discipline and it pits (primarily middle-class) people who like to be seen to control and limit or abstain from unhealthy and addictive “out of control behaviours”, such as smoking, drinking and eating junk food, against those (primarily working class people) who do not (1977). The latter can therefore be perceived as lacking in self-discipline, as being feckless and/or irresponsible – descriptors historically associated with the poor (Graham, 2012). In this way, tobacco use maps onto class tensions, becoming increasingly associated with the poor (Graham, 2012). Chapman and Freeman outline the subtexts to denormalisation and the spoiled identity of smokers (2008). Because of the “*relentless tide of bad news about smoking*” in health education, the news, and the media, smokers are now seen as malodourous, litterers, selfish, employer liabilities, addicts, excessive users of health services, and belonging to a social underclass (2008: 26-27).

The current stigma of smoking contrasts to the way in which smoking was perceived in the Victorian age (at least for men) when it was predominantly a practice of rich and powerful white middle-class men who had the financial means and social status to smoke hand-rolled cigars. Mass-market production, due to the invention of the Bonsack machine in 1883, led to a drop in price and increased availability. Smoking became accessible to groups with less social status and less money, such as women and the working classes. The 1940s saw UK smoking prevalence peak at 80% of men and 40% of women smoking across all social groups (Hilton, 2000).

The catalyst for the change in the perception of smoking from something that used to be considered sophisticated, or at least accepted, to one widely considered undesirable is often attributed to evidence of smoking causing cancer. Such evidence became widely known with the publication of two major reviews of evidence on the association between smoking and morbidity/mortality by the RCP in the UK (1962) and the Surgeon General in the US (1964) and the subsequent health education campaigns delivered via the mass media. As the public's awareness of the link between smoking and cancer increased in the 1960s, smoking prevalence declined (Marsh and Matheson, 1983, Wald and Nicolaides-Bouman, 1991).

However, the decline has been significantly greater and faster in higher socioeconomic classes (Wald and Nicolaides-Bouman, 1991). Today, tobacco use is stratified by social class. It has significantly reduced in the middle classes while maintaining a strong hold on the working class (Kaiserman, 2002, Killoran, Owen and Bauld, 2006), sparking questions over why it is that poor people smoke more. Jarvis and Wardle (2006) note that disadvantaged people are likely to want to give up smoking as much as advantaged people, claiming there is a risk that current tobacco control policies "without fresh thinking, may well succeed in further reducing prevalence, but only at the cost of still wider health inequalities" (2006:235).

Increasingly forceful tobacco control measures, the change in public perception of smoking and SHS and the decline in smoking convey the social unacceptability of smoking and SHS exposure and have contributed to creating a social climate in which smoking and smokers are stigmatised (Graham, 2012:83, Bell et al, 2010, 2012). Hilary Graham argues that smoking has become one of the recurrent signifiers of social class and moral worth, playing a pivotal role in widening the smoking gap of the late twentieth and early twenty-first centuries (2012). Because maternal smoking is more strongly associated with SHS than paternal smoking practices, a moral discourse has emerged in the SHS narrative around parental (and particularly maternal) responsibility. Indeed, Graham highlights "*the figure of the smoking mother*" as one met with contempt in media discourse (2012:92-93). With stigmatisation and discrimination only possible against groups lacking power, be it social, economic and/or political, in relation to those imposing the stigma (Link and

Phelan, 2001), smoking “*invites the attachment of moral stigma to the residue of the population that continues to use*” tobacco (Zimring, 1993:99). In this way, class, stigma and smoking are intricately linked.

The body, stigma and smoking have been associated consistently in the public consciousness. As early as the mid-60s, a large survey of adults and adolescents’ smoking attitudes and habits found that half the population agreed that “smoking is a dirty habit” (McKenna and Thomas, 1967:259). Individuals who smoke have been found to be portrayed as smelly, selfish and unattractive in the Australian media (Chapman and Freeman, 2008), and in England, people who do not smoke said those who smoked are “outcasts”, “lepers” and “disgusting” with explicit reference to odour and appearance (Farrimond and Joffe, 2006), as described by people who would rather people did not smoke near them (Lader, 2009).

People who smoke are aware of the increasingly negative connotations associated with smoking (Wiltshire et al, 2003, Stead et al, 2001). For example, older people who smoke and have arterial disease describe how smoking has gradually become socially unacceptable (Parry et al, 2002), people with lung cancer feel their disease is stigmatised because of the implication that they have caused it themselves by smoking (Chapple et al, 2004), and a Scottish study post-smokefree legislation suggests that people who smoke have internalised the stigma of smoking (Ritchie et al, 2010). As well as self-stigmatisation, there is evidence of more resistant responses to negative stereotypes of smokers, with, for example, people who smoke providing accounts on how they protect those around them through considerate practices (Poland, 2000), particularly mothers who smoke and talk about how they protect their children from SHS (Coxhead and Rhodes, 2006, Holdsworth and Robinson, 2008, Robinson and Kirkcaldy, 2007ab). These studies will be examined in more depth later in this chapter.

Some tobacco control campaigns have used negative representations of people who smoke to encourage quit attempts and dissuade initiation. Notably, the Health Education Authority’s “The Ugly Smoker” campaign played on the negative stereotypes of how people who smoke smell and look (HEA, 2005 in Farrimond and

Joffe, 2006). Slogans targeting girls and women included “Smoking makes your teeth minging” and “You smoke, you stink” and those at boys and men targeted their concerns about virility and used the fear of social embarrassment. By tapping into these moral undertones and the negative stereotypes of people who smoke, tobacco control advocacy has been accused of conflating medicine and morality and to have a number of characteristics of a “moral crusade” (Klein, 1993, Bell et al, 2010), deliberately invoking the stigmatisation of smoking and, by extension, those who smoke.

Given the way in which the tobacco industry would presumably seize and use any findings of negative consequences of tobacco control measures, the tobacco control literature has, until recently, been somewhat reluctant to critically explore any negative consequences of tobacco control measures. Lately, however, many commentators have recently called for the need to take notice of and counteract these unintended negative effects of denormalisation (for example Burgess, Fy and van Ryn, 2009, Ritchie et al, 2010 Burris, 2008; Bell et al, 2010). Little is known to date about how the stigma of smoking affects children or, if they are aware of it. The question of whether intentional stigmatisation is ever justified will be revisited in Chapter 8 in the light of the findings of this thesis. This chapter now turns to an overview of children’s understandings of smoking and SHS.

2.5. Smoking restrictions in the home and car

Socioeconomic status – the position a person occupies in the structure of society due to social or economic factors (Galobardes, Shaw, Lawlor, Lynch and Davey Smith, 2006) – has consistently been found to be a predictor of smoking status and practices and constitutes a key variable in children’s exposure to SHS in homes and cars. People who live in socioeconomically disadvantaged circumstances are more likely to smoke, smoke more, less likely to quit and are more likely to live in an area with more permissive smoking norms (Jarvis and Wardle, 2005, Sims et al, 2010, Hiscock, Bauld, Amos, Fidler and Munafo, 2012). People in disadvantaged circumstances are also more likely to smoke in the presence of children (Johansson, Halling, and Hermansson, 2003), and smoke in their homes and cars (Bolte and

Fromme, 2009, Phillips et al, 2007). In Scotland, 65% of 10- to 11-year-old children from the most disadvantaged homes reported that one or both parents smoked compared to 35% of children from the most advantaged homes (Akhtar, 2009).

In 2007, the percentage of 11-year-old children in the Scottish CHETS study whose parents smoked who reported smokefree homes was 19.3%, the percentage of children reporting partial restrictions was 53.3%, and 27.4% reported no restrictions. In homes in Scotland, the percentages of children reporting no restrictions fell from 18.5% in 2006 to 14.2% in 2007 and the percentage reporting smokefree homes rose from 47.3% to 51.2% in the same time period (Moore et al, 2012). Similarly, 29.1% of the Scottish sample reported that smoking was allowed in the family car(s) prior to the implementation of the smokefree legislation, declining to 25.7% afterwards (Moore et al, 2012), which, when combined with the (very similar) reductions in Wales and Northern Ireland, was statistically significant. Among children living in Scotland whose parents smoke, 18.3% reported smokefree homes pre-legislation in 2006, 45.5% had partial restrictions and 36.2 % had no restrictions (Moore et al, 2012).

Following the legislation, in 2007, the percentage of children who reported smokefree homes had increased by 1% to 19.3%, the percentage of children reporting partial restrictions increased, to 53.3%, and reports of no restrictions reduced to 27.4%. This change indicates a move towards more stringent restrictions within a space of time that suggests an effect over and above that of a secular change (Akhtar et al 2007, 2009). However, while the smokefree law was associated with a reduction in children's SHS exposure across all socioeconomic groups, for children whose mothers and fathers smoked or for those whose mothers smoked, SHS exposure did not significantly reduce (Akhtar et al, 2007). Inequalities in SHS exposure among children were present before and after legislation, and inequalities post-legislation could be increasing (Akhtar et al, 2009).

The evidence that partial smoking restrictions within homes works to reduce SHS levels is not particularly strong. Swedish research demonstrated that only outdoor smoking with the door shut reduces SHS exposure as was evident in children's

cotinine levels in more than a minimal way (Johansson et al, 2003, 2004). According to the justification for “pledge” approach interventions, indoor smoking restrictions may constitute a first step towards creating a smokefree home, however. There is evidence that smoking restrictions have other benefits. They are associated with a reduction of smoking uptake among children and adolescents (Raine and Rimpela, 2008), that growing up in a home where smoking is subject to restrictions makes young adults prefer smokefree homes when moving out (Albers, Biener, Siegell, Cheng and Rigotti, 2009) and smokefree homes are known to decrease smoking and increase the success of quitting attempts (Shields, 2007).

The CHETS studies provide representative and powerful data to support what comprehensive smokefree laws can achieve, despite having a number of limitations. First, parental smoking may be under-reported, or smoking restrictions over-reported. Self-reports of an increasingly stigmatised behaviour such as smoking have inherent issues of validity as shown in studies of pregnancy and smoking (Boyd et al, 1998) and of smoking in general (Thompson et al, 2006: 184). Second, response options regarding smoking restrictions were limited and imprecise, including whether smoking took place in the home or not, and if it took place only on special occasions or in set locations. These options are open to interpretation, for example a “special occasion” could be defined as either Christmas and birthdays or when grandparents visit several times a week. Similarly, smoking allowed in “set locations” could refer to the kitchen doorway only or everywhere but a child’s bedroom.

Other work has also shown that smoking restrictions are more fluid and dynamic than suggested by survey responses (Phillips et al, 2007, Robinson and Kirkcaldy, 2007, Jones et al, 2011). A certain imprecision is perhaps inevitable in any large scale study, yet particularly problematic in smoking research given the probability of misconstruing children’s responses about smoking when not sensitive to the ways in which such responses are informed by their (developing) understandings of smoking practices and the context of their narratives (Mair, Barlowa, Woods, Kieransa, Milton and Porcellato, 2006). It is not that children deliberately provide “false” or inconsistent reports, but that we may need to delve a little deeper to understand what

they mean by smoking being allowed or not within the home and car. Thirdly, children were asked only to report SHS exposure on the day before the survey because their recall was thought to be less reliable if over a longer period (Akthar et al, 2007). It is not clear what this statement of 11-year-olds' memory span is based on and asking children to recall SHS exposure from the previous week may have captured regular smoking patterns better.

Akthar et al also use the Family Affluence Scale (FAS), a "child-friendly" questionnaire that determines SES (socioeconomic status) by family car ownership, bedroom occupancy, family holidays and computer ownership. I applied the same measure in my study and will provide a detailed critique of it in that context in Chapter 4. This critique rests on the assumption inherent in FAS that computer ownership is an accurate measure of SES and whether postcode may capture SES better than bedroom occupancy (although many children may not know their postcode). In anticipation of such a critique, Akthar et al compared the use of parental SES and FAS measures and found that it made no difference to SES categorisation (2007).

Explanations derived from limited response options in pre-designed surveys may constrain our insight in the everyday lived experience of smoking in the home by obscuring or minimising social, cultural or interpersonal factors in favour of variables such as age, class and gender. While still limited, the next Scottish Health Survey will include more detailed questions about smoking restrictions than ever before with four response options ranging from "people can smoke anywhere inside/in certain areas/outdoors" and will pose questions about SHS exposure to children for the first time (Catherine Bromley, private correspondence).

According to Rugkåsa et al, one reason for the limited research on family dynamics and smoking restrictions in the home from a child's perspective may be the "relative absence of sociologists and anthropologists from the field of childhood and adolescent smoking", resulting in fewer qualitative studies and even less studies with a sociological approach of the everyday lived experience of being exposed to SHS from a child perspective (2001: 131). Such an understanding of SHS risk in the

home, and smoking restrictions and negotiations, may hold the key to successful interventions. Indeed, current understanding of the establishment, maintenance and negotiations around smoking restrictions (sometimes referred to as smoking “rules”) owes much to work with a social scientific perspective and qualitative methods.

Qualitative contributions have served to illuminate some of the factors pertinent in the social process around restrictions, particularly negotiations and the nature of participants’ accounts of them. Before moving on to these issues, this section ends with an outline of the available evidence for the numerous factors associated with smoking restrictions. Smoking restrictions can be divided into two main categories: spatial and situational/temporal (Goldstein, 1994). Spatial restrictions refer to never allowing smoking in the home, in a particular room or rooms in the home, or not allowing smoking in the car. Situational or temporal restrictions refer to restrictions that operate during certain times, such as when children are present, or those eased when certain people are present or during parties. Research has suggested links between the establishment and maintenance of spatial and temporary smoking restrictions and a number of factors, including smokefree legislation, SES and factors potentially related, such as the number of people who smoke in the home, less space and more permissive smoking norms, aesthetic factors and the presence of children and relational factors. Many of these are, of course, interrelated.

As previously discussed, changes to smoking restrictions may be due to gradual changes over the years prior to the smokefree law and not due to a direct effect of the law, as reported by participants in a Scottish study (Phillips et al, 2007, Robinson et al, 2010). However, a minority of women in this study reported that they would feel uneasy about smoking in public post-legislation and therefore wait till they got home to smoke (Robinson et al, 2010).

Overall, however, the smokefree legislation has been linked to more stringent restrictions in homes and cars (Moore et al, 2012). As also discussed previously, smoking restrictions have been found to be less stringent in lower socioeconomic groups, who have more spatial and temporal exceptions in their homes and where smokefree homes are less common (Akthar et al, 2007; 2009, Bolte and Fromme,

2009, Phillips et al, 2007, Sims et al, 2010). Indeed, when breaking the percentages in the CHETS studies down by SES (as measured by FAS) between those least and most advantaged there are significant inequalities in smoking restrictions. Of the least advantaged children in the four UK countries, 26.3% reported living in a smokefree home and 51.7% reported that their cars were smokefree as compared to 72% of those most advantaged children reporting a smokefree home and 83% a smokefree car.

Lack of space, both indoors and outdoors, entail a particular (but not exclusive) challenge for people in disadvantaged areas, particularly those who smoke and live in highrise buildings and/or without balconies. Small children can add a further dimension to make a smokefree home more difficult as it can be seen to conflict with caring responsibilities as leaving small children alone may be associated with more risk than exposing them to SHS (Coxhead and Rhodes, 2006, Robinson and Kirkcaldy, 2007). At times, other priorities can also conflict with SHS management, such as financial/relationship problems where smoking can be viewed as a coping measure (Poland et al, 2009).

Public awareness of the association between SHS and ill health of children is high and the presence of children or the arrival of a new baby is one of the most frequently cited reasons for restricting smoking in the home and car (Ashley and Ferrence, 1998, Phillips et al 2007, Robinson et al, 2010, Wilson et al, 2012). Such knowledge tends to rely on a broad acceptance of risk rather than a comprehensive understanding of effective ways of protecting child health.

Some mothers who smoke challenge the official discourse of SHS risk to child health, drawing on the experiences of growing up in homes with few smoking restrictions, or of other children growing up in smoky homes without any obvious health effects, as discussed in depth in the next section (Holdsworth and Robinson, 2008, Robinson and Kirkcaldy 2007ab, Coxhead and Rhodes, 2006). This is particularly clear in accounts from qualitative studies with disadvantaged mothers that underscore the moral nature of their rationalising and their smoking behaviour around children. As is the case with surveys, self-reporting may be seen to have

inherent issues of validity and Mumford warns that in homes where adults smoke and children live, participant's accounts of smoking restrictions "are especially at risk of inconsistenc[y]" (Mumford, Levy and Romano 2004:126). However, the strength of qualitative research lies in the analysis of why people might strategically answer in a certain way and what such accounts can potentially tell us about social norms around a particular behaviour (Holstein and Gubrium, 1995).

Coxhead and Rhodes' study (2006) with mothers who smoked, whose young children had been hospitalised due to respiratory issues, identified their main strategy to protect children from SHS was spatial separation. Such strategies varied between smoking near children but with an open window to smoking outside. Two main accounting styles were apparent in the mothers' accounts: stories of "agency" where agency is denied on the basis of addiction, for example; and stories of "acceptability", where the mother denied the full risks of SHS. A third style was also apparent at times; "reflections of guilt", evident when participants switched between the two accounting styles. Underscoring these accounts is a theme of morality. In describing their smoking restrictions, these mothers appear to be accounting for, and defending, their parental (maternal) role of protecting child health by smoking "responsibly" in a controlled manner and putting their children first. Some mothers justified smoking in the same room as their children by saying it protected them from the greater risk of not being supervised – a finding which is echoed in other studies (Robinson and Kirkcaldy, 2007). Others questioned the extent of the risk SHS posed and many expressed guilt at smoking. Accounting styles were interwoven and complex, testifying to the need to defend smoking as a parent. Here, a clear indication of the harm smoking can cause the children did not always spark increased restrictions, something Poland et al (2009) also found in a few cases, such are the external (and internal in terms of doubt about risks) barriers present for some families and in some homes.

Fathers have been – and still are to some extent – largely ignored in theory and practice around promoting smokefree homes and environments for children (Gage et al, 2007), reflecting a contemporary and gendered discourse which is more forgiving of men's smoking (Bottorff et al, 2006). Recently, however, studies around fathers'

perspectives of smoking reduction during the pregnancy and postpartum period have emerged (Blackburn, Bonas, Spencer, Dolan, Coe and Moy, 2005, Bottorff et al, 2006, 2008, Greaves, Oliffe, Kelly, Greaves, Johnson, Ponc et al, 2010). Reporting on an interview study with 29 new fathers in Canada, Bottorff, Greaves and colleagues highlight that smoking is also becoming incongruent, not only with current discourses around being a “good mother”, but also a “good father” (Bottorff et al, 2008, Greaves et al, 2010). The fathers in this study position themselves in their accounts as concerned about protecting children from SHS and discussed attempts to stop, or reduce, their smoking to be better role models for their children and to protect their health, but speak less of where they smoke or where they did not. Still, little is known about fathers’ perspectives around smoking restrictions and children. In a study of mothers’ perspectives of their children’s father’s smoking, mothers defend it by saying fathers restrict their smoking temporally or spatially by not smoking around them or their children, but few details of specific restrictions are given (Bottorff et al, 2009). Recent studies on the relational dynamics around smoking offer the beginning of a deeper understanding of fathers’ smoking and the family dynamics and this topic will be discussed in greater depth in the next section.

Finally, aesthetics is a frequently reported reason for introducing and maintain smoking restrictions in the home and car. Avoiding or reducing the nicotine stains on walls and the tobacco odour, which can cling to soft furnishings, can motivate smoking restrictions (Jones et al, 2011). The stigma associated with a home smelling of smoke is remarked upon by participants in Holdsworth and Robinson’s study of mothers who smoke saying they dislike going to other people’s houses with no smoking restrictions where the paintwork is yellow and the way in which people smell (2008). Further, moving house or from rented to owned accommodation, a new car, or decorating can also be examples of a catalyst and motivator in the modification of smoking restrictions stringency (Phillips et al, 2007, Jones et al, 2011). The management of the smell and smoke does not necessarily involve smoking outside but can also involve measures to mask the smell, such as the use of air-sprays, air purifiers and incense as well as opening windows and doors (Poland et al, 2009).

This section has outlined some of the levers and barriers to smokefree homes. There is also evidence that caregivers, particularly those who are disadvantaged, face significant challenges when trying to implement and maintain a smokefree home, given the substantial behavior change that may be required for them and others (Blackburn et al, 2003; Phillips et al, 2007; Robinson and Kirkcaldy, 2007ab). The next section explores evidence that one such challenge might be the negotiations required around smoking restrictions with other household members (Robinson et al, 2012).

2.6. Family dynamics around smoking and SHS

One of the aims of this study is to examine children's perspectives of child and parent negotiations around smoking restrictions, which, to my knowledge, no other studies have, to date. This section will therefore examine adult interactions instead and explore child and parent interactions from their perspectives.

The need to further study the social context in establishing and maintaining home and car smoking restrictions has been noted (Robinson et al, 2010, Poland et al 2006). Such is the individual variability and complexity of the interpersonal management of SHS in the home that it must be understood in the context of the relationships within the family (Poland et al, 2009). An increasing number of qualitative studies have heeded this call and furthered our understanding of the dynamics within couples, families and wider social networks related to home smoking restrictions. In examining the social process within families, scholars have attempted to categorise and distinguish between different patterns of interaction (Bottorff et al, 2010, Robinson et al, 2010) and have found these to be underpinned by power, which has in turn been linked to gender (Bottorff et al, 2010).

Gender is itself a key element to all areas of tobacco control research as a recent review by Amos et al (2012) has demonstrated. With higher rates of male than female smoking and more traditional gender power hierarchy within relationships in the Majority world, women may find it very challenging to impose smoking restrictions in the home unless the men approve or initiate them. Similarly, gender

and gender inequalities can also be an important factor in couple dynamics around smoking in the home in the Minority world. The term “Majority world” refers to the developing world and “Minority world” refers to the developed world and reminds us that most people in the world live in the economically poorer continents of Asia, Africa and Latin America, whereas only a minority of the world’s population live in the richer areas of the globe (Europe, Australia, New Zealand, Japan, USA and Canada). A binary distinction such as this is, of course, simplistic, as countries such as China fall between the two categorisations and there is much diversity within the two categories (despite being categorised in the Majority, World South Asia and Latin America have different levels of poverty, for instance).

The works of Joan Bottorff, Lorraine Greaves and their colleagues have made a particularly important contribution to our understanding of the social dynamics of tobacco use in private settings. Using a gender lens, such studies demonstrate that the negotiations around smoking restrictions often reflect inequalities between men and women (Bottorff et al, 2006, 2009, Greaves, Kalaw and Bottorff, 2007). In a case study article they outline different ways for couples to relate around women’s smoking during pregnancy and in the post-partum period (Greaves et al, 2007).

Acknowledging that “power and control are part of everyday life in many relationships and interpersonal contexts” (2007:325-6), they underscore the numerous unequal ways in which men can exert their power to control women’s smoking. They identified different patterns of interaction that couples engage in. For example, conflictual patterns characterise patterns of tense, judgemental and, at times, hostile interactions around women’s smoking. For instance, one man was reported to refuse to give his partner money to buy cigarettes with the words “*I’m not gonna support your dirty habit*” (2007:328). Disengaged styles of interaction were present when smoking was not subject to discussion but presented as an individual practice.

While such patterns of interaction were often established prior to pregnancy, the authors argue pregnancy triggered and intensified patterns because of “compelled tobacco reduction” arising from public and policy discourses that target pregnant

women who smoke (2007:326). Some of the men in the study were also reported to induce guilt, saying that smoking is not compatible with caring for a child. As such, this study is an example of how public smoking denormalisation discourses can be used to criticise women's smoking practices in couple interactions. Greaves and her colleagues state they have identified patterns that are "consistent with elements of power and control in abusive relationships" (2007:330).

Women use similar discourses in interacting with their partners who smoke, however. In a later paper, they present women's accounts of both defending and moderating men's smoking practices (Bottorff et al, 2009). Some quotes are not dissimilar from those that men are reported making to women in the earlier paper. For instance, women used language to make men feel guilty by drawing attention to child health problems they were said to be causing and reminding them of their responsibilities as role models (2009:591). However, Bottorff et al point out that the women were careful to try and maintain good relations and therefore didn't "nag" (2009:591). The analytic emphasis in this paper is on the ways in which women defend their male partners' smoking, however.

Echoing the findings of Hilary Graham's classic study on the role smoking plays in mothers' caring roles in disadvantaged circumstances (1987), women in this study state smoking is their partners' "little thing", which women have no right to influence. Second, women in this study defended their partners' smoking by minimising its potential impact: saying they smoked without children present and/or outwith the home. Smoking as a treat well deserved was used as a third line of defence of fathers' smoking, and fathers were positioned as protective of children's health by not smoking around them or their children, as mentioned in the previous section (Bottorff et al, 2009).

Distinguishing between different Canadian households' restrictions according to whether they had a high, moderate or low degree of smoking restrictions, Poland et al (2009) examine whether the interaction patterns surrounding restrictions are negotiating, modifying, resisting and/or enforcing them. Some of the households in Poland's study were found to have clear and consistent restrictions and others as

having few and inconsistent restrictions, most of which have evolved over time and which have gradually reduced the areas in which smoking is permitted within the home. While some restrictions were subject to much negotiation between family members, others were unspoken and either pattern of interaction could lead to a smokefree home or one with few restrictions. Poland et al (2009) observe that homes with more than one adult who smoked tended to have less stringent restrictions, a finding reflecting Akthar et al's survey research in Scotland (2007).

The work of Jude Robinson and colleagues have added to, and expanded, on this work by exploring the negotiation of restrictions with family and wider social networks following the smokefree legislation in Scotland (2010). Categorising such interactions as volunteered, negotiated and enforced, Robinson et al (2012) confirms that negotiations can be mediated by gender and also the relative power of the relationship between those negotiating. Voluntary restrictions refer to the description of the establishment or increased stringency of restrictions as a smooth process that had happened by mutual, and at times unspoken, agreement. Other participants described restrictions as having been negotiated and a few accounts described them as enforced. Negotiations would involve a request by parents to grandparents and others not to smoke in their homes or around children. In one instance, a parent had asked a grandparent not to smoke in her own home when looking after the child and explicitly used access to the child as leverage. Social sanctions similar to these illustrate the tension that smoking in the home can give rise to, or perhaps reflect. Reflecting on a previous study in England, Robinson (2008) found that those participants sometimes found asking visitors to smoke outside "inhospitable", however, in this study no such concerns were expressed and participants were adamant that the same rules applied to visitors.

While there is an absence of studies explicitly exploring child agency in the negotiations of smoking restrictions, however, glimpses of this exist in the reports by adults. Adult participants mention children nagging to persuade them quit (Phillips et al, 2007) telling them that they are "smelly" (Robinson et al, 2010), or attempting to protect themselves from SHS by walking out of rooms when someone smokes (Poland et al, 2009). Adults thus acknowledge and appear to take children's protests

relatively seriously yet children's views or accounts remain peripheral in many existing studies.

As this section has demonstrated, family dynamics related to smoking practices are complex and idiosyncratic. Negotiations can be tense, even abusive, and protracted, or they can be smooth, unspoken and swift. Fathers' perspectives are beginning to emerge, but children's perspectives are never the focus and often peripheral in studies. Given this complexity, the diversity of factors that can affect smoking restrictions in homes and cars and the still limited knowledge of different family member's perspectives, designing and implementing successful interventions can be challenging, as the next section will testify to.

2.7 Smokefree home and car interventions

Research has established a lack of effective smoking restrictions in many homes. While there are US and Canadian examples of multi-occupancy buildings where smoking is no longer allowed (NY Times, 26.01.09), there is a general consensus that legislating is not a feasible option given a lack of public support, and the cost and challenge facing implementation (RCP, 2010). Unlikely to be subject to legislation in the foreseeable future, finding other ways to encourage smokefree homes and cars is therefore vital to reduce smoking prevalence and protect the health of children.

Consequently, there have been numerous interventions ranging in design and scope from small qualitative pilot studies to large random controlled trials (RCTs) to address smoking reduction in the home and car. Such interventions have been the subject of three recent reviews (Gehrman and Hovell, 2003, Priest, Roseby, Waters, Polnay, Campbell, Spencer et al, 2008, Baxter, Blank, Everson-Hock, Burrows, Messina, Guillaume et al, 2011) and a review of the statistically significant studies from these reviews (Shaw et al, 2012).

Intervention studies are heterogeneous in content and methods. They include a range of methods including counselling, education and feedback on cotinine and air quality

measures (frequently in combination) and have been delivered both in clinical and community settings by health care professionals, community workers and/or researchers. The heterogeneity in design, outcome measures and quality makes the evidence challenging to synthesise (Shaw et al, 2012). Further, statistically significant findings are often modest, seldom sustained and almost always self-reported. Compared to the well-established field of smoking cessation interventions for example, this is, in many ways, a field in its infancy.

Potentially, however, it appears that community-based multi-faceted interventions delivered over a longer time can reduce SHS exposure for children. For instance, Alwan (2010) designed and delivered a six-month intervention consisting of a smokefree home (SFH) team visiting primary schools in the north of England and used a SFH toolkit that involved undertaking activities with children aged between 9 and 11. The children were also provided with “promise forms” to take home to parents who could choose to undertake a smokefree home pledge. Perhaps the most popular and widely used intervention design, pledge systems involved parents undertaking pledges not to smoke indoors in a stepped fashion where they promised not to smoke in more than one room and/or in front of their children. To symbolise and remind them and others of their commitment, they are provided with a certificate to put on their wall. The SFH team trained health professionals and other community workers to encourage their clients to impose smoking restrictions at home, organised community-based events and provided educational materials. Of the 318 households surveyed where the initiative was staged, the number of smokefree homes increased significantly from 35% at baseline to 68% six months post-intervention. However, when smoking households only were measured, there was a small and non-significant increase from 41% smokefree homes at baseline to 48% post-intervention. This study was not randomized and the findings were based on self-reporting and the effects non-significant in the homes most in need of a reduction in exposure, yet it is noteworthy because it is one of the very few that take child agency into account.

In another English study, local community members were trained and employed to deliver a SFH intervention to parents of young children, older people and people with respiratory problems (Hacker and Wigg, 2010). Participants were asked to sign

up to a three-stage promise – gold, silver and bronze – and were re-visited after one month to assess whether they were ready or willing to upgrade their original promise. A total of 3,261 promises were made with 47% from homes with at least one smoker. At the follow-up stage, 17% of surveys were returned, of which 5,163 (81%) reported making some change such as attempting to quit (14%), quit (25%) or cut down (42%). Marginally over two-thirds (68%) also reported changes in the behaviour of other adults in the house. While showing some positive results, including reportedly improved health for those with a respiratory condition, there was a low follow-up response rate and the findings were, again, based on participants' self-reporting.

Self-reports and low follow-up response rates constitute the key limitations of the studies examined, particularly in relation to the “promise” or “pledge” interventions. The promising increase in community-based SHS interventions in the UK over the last decade is therefore marred by the lack of rigour in methods and evaluation.

The design of a recent Scottish study addresses many of the limitations of earlier intervention studies (Wilson et al, 2012). The point of departure for the Reducing Families' exposure to Secondhand smoke in the Home (REFRESH) study was previous evidence suggesting that interventions have been more effective in reducing children's SHS exposure when there has been longer and more involved contact with parents who smoke. Such studies have primarily been based in clinical settings and the REFRESH study therefore wanted to explore a home-based intervention that involved extended contact with the family. Mothers who smoked with children under the age of six were given personalised feedback on the air quality in the home, as part of a motivational interview. Despite sending out 1693 invitations via GP practices, recruitment proved difficult and the researchers only recruited 59 mothers who they randomised into a standard (control) or an enhanced group. While both groups received a motivational interview, the enhanced group also received personalised air quality feedback from a monitor placed in their homes. The monitor measured levels of fine particulate matter in the indoor air ($PM_{2.5}$)/smoke over 24 hours at two time-points with 4 weeks in-between measurements. $PM_{2.5}$ is a measurement of the concentration of fine particles suspended in air, used as a

surrogate measure for SHS exposure as smoking produces particles with a diameter <2.5 microns. Mothers in the enhanced group received a graph and information on how their air quality altered depending on when they smoked.

The findings from the intervention show a small non-significant greater reduction in PM_{2.5} levels in the enhanced group and a statistically significant reduction in the maximum levels in the same group. The children in the enhanced group had a greater level of salivary cotinine from the start and this remained the case post-intervention, albeit reduced. The mostly non-significant results may not be due to the method but the small numbers of participants. The interview results show participants appreciated the way in which the intervention had been delivered in a non-judgemental and understanding way, illustrating that they had perhaps had different expectations or concerns about judgement. This suggests a recruitment strategy based on personal contact with potential participants would have been more successful where a non-judgemental approach could have alleviated any potential concerns about being judged as a smoking mother (see stigma discussion later in this chapter). As in other studies (Robinson and Kirkcaldy, 2007ab, Robinson et al, 2010, Coxhead and Rhodes, 2006), findings suggest the main motivation for smoking restrictions is to protect children, discussed later in this chapter.

Other smokefree home initiatives are unpublished, identified through a mapping study by the REFRESH team. Their mapping study shows that 10 of Scotland's 14 health boards delivered smokefree home interventions in 2010 (Shaw et al, 2012). Interventions were relatively limited in range and activities, with stepped pledge systems and "training the trainer" interventions being the most popular. However, seven health boards target and involved children and young people and, in some cases, collaborated with them to produce leaflets, DVDs, art projects and posters about SHS and smokefree homes. NHS Greater Glasgow and Clyde have been particularly active and have smokefree initiatives operating as part of an anti-smoking campaign called "Smoke-free Me" with over 90% of primary schools participating in 2009/2010 (as mentioned in Shaw et al, 2012).

While innovative and encouraging, many such initiatives are still at an early stage of

development, have short-term funding and few have (or will be) evaluated. They represent pockets of action in different health boards rather than a nationwide approach based on evidence for what works best. At the time of writing, there are no Scottish Government targets for reducing children's SHS exposure.

2.8. Child perspectives on SHS

To date, there are, to my knowledge, only two in-depth studies on children's perspectives of smoking in the home and SHS, examined in detail in this section. With the book, *Growing Up in Smoke* (1990) and preceding papers, "Clean air kids and ashtray kids" and "The family atmosphere" (1989ab), Lynn Michell pioneered research into children's views and understandings of SHS. Based on multiple-choice questionnaires distributed via schools to 658 10- to 14-year-old Scottish children, these insightful works remain, more than two decades later, the most comprehensive study of children's views and experiences of SHS to date. Her sample, drawn from three areas in Edinburgh of contrasting socioeconomic profiles, consisted of 60% of children who lived with family members who smoked. Michell asked children where people smoked in their homes, and if they had ever asked anyone not to smoke, thereby focusing on children as active social beings. Michell reports the emotive and strong comments that many children provided in response to the final open-ended questionnaire question: "*How do you feel about other people's smoking?*" Comments highlight the sense of injustice and incomprehension that particularly younger children feel on being exposed to SHS and adults' smoking, respectively. The anger and frustration is evident in one 13-year-old boy's written comment:

If other people want to smoke and make their lungs all black and full of crap it's up to them. I've asked my Dad, the only one who smokes in our house, not to smoke but he still does.

Children also expressed their concern about the health of their family members. For example, one 12-year-old girl showed her concern, fear, anger and frustration in the following comment:

I am very worried about my mum and dad smoking just in case they catch lung cancer or something but I suppose it's their own fault but I am still

scared and I don't know what to do.

Rich data and strong views such as these indicate children engaged with the issue. While being an impressive and forward-thinking study, the study design does have limitations. When requesting information about home smoking restrictions, Michell's questionnaire fails to separate out rooms in the house but conflates kitchens and living rooms as "shared spaces" and does not request any information on when smoking occurs there, but if it "normally" does. This categorisation may be confusing to participants who may be uncertain how to respond if smoking only occurs at certain times or in certain situations, however irregularly or regularly these occur. Furthermore, participants are asked "What is your home normally like?" and are given the following response options: "very smoky"; "sometimes quite smoky"; "a bit smoky" and "never smoky". Such response options suggest that it is assumed that respondents would not only know what to relate their own home's "smokiness" to, but will also be able to differentiate between the (fairly indistinguishable) categories of "sometimes quite smoky" and "a bit smoky".

While these two examples are perhaps too broad, others are too specific. For example, to assess children's exposure in different modes of transport, children are specifically asked if they sat in the "smoking seats" "the last time" they travelled. Other questions are potentially leading: "Do you think people should smoke in your home?" rather than "Do you think people have the right to smoke in their own homes?" and including response options such as "if they live alone/with no children" may have prompted different and more nuanced answers. To date, and despite any such minor limitations, Michell's study remains the key study of children's views and understandings of SHS.

More recently, in the Liverpool Longitudinal Study on Smoking (LLSS), Porcellato et al (1999) mapped the development of 256 children's smoking and SHS perspectives (Woods et al, 2005) between the ages of 4 and 8 across six Liverpool primary schools located in areas with a range of (predominantly) low to high socioeconomic status. Using a combination of draw-and-write methods (with 976 participants), a survey (1701 participants) and individual interviews (50 participants),

Porcellato and her colleagues found that the children expressed mainly negative views of smoking and were aware of the health impacts of smoking on the body. However, when exploring the questions they were asked, an alternative analysis of children's answers appears possible, even plausible. At times, Porcellato reports children's answers as if they represent objective reality. For example, they reported 94% of their sample had never tried smoking a cigarette. Porcellato et al do not acknowledge the social desirability of the answer for young children completing a questionnaire administered at school. Other questions appear leading, for example, children were asked to "write how they can tell from the inside of the body" that someone has been smoking for a long time. The implication is that the inside of a person's body changes from smoking, something that the children may not have been aware of.

Children were also asked to imagine and then draw-and-write what being in a room full of smokers would feel like and "What, if anything, they would say to the smokers?" The children who participated in interviews were asked "If people are smoking near you how do you feel?" and "Can you tell me what the term passive smoking means?" The authors report that while the children were unaware of the meaning of the "term passive smoking", they disliked being exposed to it and had some understanding of the health risks SHS posed to both themselves and the person who smoked (Woods et al, 2005). Children aged between 4 and 5 responded negatively and emotively to being amongst smokers and, increasingly, as they got older they were concerned about the health of the person who smoked as well as their own health.

Woods et al (2005) comment on and appear to express surprise about children's apparent lack of agency, or "direct action", as they call it, to communicate their dislike of smoking to family members who smoked in their presence:

Yet whilst they express such dislike and concern over the issue during their early years, they are very reluctant to take direct action and remove themselves from the situation. Instead they rely on the actions of their parents to protect them from ETS. In our study of 4-8 year-olds we found that while this does happen, it appears to be only in a minority of households. (2005: 9-10)

In their conclusion, Woods and her colleagues suggest that encouraging children to leave a room when smoking adults are present may be a rewarding research path to explore in future interventions. While emphasising children's potential for agency, such a suggestion also discounts the restrictions placed on it. For instance, Woods et al recruited primarily from low socioeconomic groups where few smokefree spaces may exist within the home if children "walked out" as parents tend to smoke in the main living spaces. Furthermore, some of these children are as young as 4 and none older than 8, therefore expecting them to leave a room where their smoking parent is appears to discount the power dynamic between adults and children at this age.

The impressive range of methods they employ in their study include a survey, Draw-and-write, interviews and focus groups and is justified by reference to claims that using triangulation, or a mixed method approach, is advantageous in a number of ways. It "adds rigour, depth and breadth", enables researchers to extricate otherwise hidden findings, establishes a thorough picture, and validates the findings through comparison with others. These mixed methods research "mantras" are often rehearsed in studies using several different quantitative and qualitative methods, but can be unpicked in several general and some more specific ways. Conceptually, there are some difficulties with assuming that several different methods validate different findings or "cancel out the weaknesses of each other" as the authors claim in one of their papers (Porcellato et al, 2005). The triangulation metaphor builds on the positivist view that there is one single truth, whereas the qualitative paradigm generally builds on an assumption that there are several different perspectives/"truths"/accounts. That is not to say that there is no value in using multiple methods, but simply that they will add a different perspective, not validate the same one (for my review of mixed methods used in healthcare research see Östlund, Kidd, Wengström and Rowa-Dewar, 2010).

Missing from these studies on children and SHS risk is an analysis of their risk accounts from a social science perspective, which I am hoping to achieve in this thesis. In the final section of this chapter, I will therefore provide a discussion of theories of risk on which I will draw in later analytic chapters.

2.9 Theories of risk

In the epidemiological literature reviewed above, the risk that SHS exposure poses to child health is framed relatively simply, albeit with some important consequences for the way in which risk perception, agency and morality is viewed. Children are passively exposed to the risk of asthma, bronchitis and the other health issues associated with SHS exposure by adults who may be unaware of the risk or who behave irresponsibly. Because any notions of child agency are missing within the literature, SHS risk is framed as an objective entity and adults who smoke around children are framed as lacking in knowledge and/or responsibility. However, studies on smoking in the home and family interactions reviewed earlier in this chapter have begun to illuminate many of the complexities that can underpin smoking practices within couple and wider family interactions. Within this body of research, risk is treated as a complex and problematic entity, echoing a wider social sciences perspective on risk as being socially constructed; intersubjectively produced and culturally located (Lupton, 1999). Rather than seeing risk as an objective or quantifiable entity, risk can be seen as “a situation or event where something of human value (including humans themselves) has been put at stake and where the outcome is uncertain” (Rosa, 1998:28). Whether a situation or event will be seen as risky will depend on many factors, including the context, culture and individual(s) involved. Individual agency which may be displayed in a resistance to expert views of risk is central to this body of work, as is the notion of responsibility and, consequently, morality and stigma, as this review will demonstrate.

Most writings from a social science perspective emphasise that heightened awareness of, and publicity about, an ever-increasing number of risks, permeate everyday life in modern Western societies (Beck, 1992, Giddens, 1991, Tulloch and Lupton, 2003). The ways in which people respond to, experience and account for risk as part of their everyday lives have been subject to a number of theories and empirical studies. This section will provide an overview and critical review of theories of risk of a sociological and anthropological nature relevant to this study. While risk theory has been drawn on to explain risk behaviour in both the sociology of health and illness (e.g. Green, 1997) and the sociology of childhood (e.g. Scott et al. 1998; Kelley et al.

1998) and, more recently, adults' smoking practices within homes (Robinson et al, 2010), children's accounts of their own (and their parents') views and responses to SHS risk remain unexplored.

The body of work relating to risk is interdisciplinary in nature, underpinned by sociological, psychological and anthropological disciplines. This section reviews some of the theories of risk drawn on in this study, namely sociological and anthropological explorations of risk, particularly the work of Mary Douglas and Erving Goffman, which points to the dynamic and varied ways in which individuals respond to risk in different cultures and within social interactions.

2.9.1. Risk society

Ulrich Beck's thesis of risk detailed in his seminal text 'The Risk Society' (1992) has influenced much sociological interest in risk behaviour. Beck famously proposes that managing risk and uncertainty have become defining features of contemporary life in what he refers to as the late-modern era. This era refers to the end of the period of transition from modern to late (or high) modernity society and is characterised by technological development in post-industrial countries with an unprecedented capacity for destruction and devastation. Alongside this development, the latter half of the twentieth century has also witnessed the creation of the welfare state; a widespread system of social interventions designed to protect the mass of society from the immensely challenging, dirty and uncertain day-to-day life that poverty can entail. Paradoxically, the majority of us therefore experience an unprecedented level of freedom from the uncertainty of obtaining food and shelter, yet technological developments have also produced dangers unprecedented in magnitude and not always detectable by our senses. Fears over scarcity of vital resources in the industrial age are thus rapidly being replaced by fears produced by uncertainty in contemporary Western societies (Beck, 1992).

In late modern society, risks are defined and determined by expert scientific knowledge rather than people's everyday experiential knowledge as many risks are invisible and not perceptible to the senses. Yet experts disagree, make mistakes in

their risk calculations and such knowledge can appear at odds with everyday experiential knowledge. Where faith in certain knowledge as “the truth” is no longer as evident and once established voices of authority are increasingly challenged, doubt has become a prominent feature in late-modern society (Giddens, 1991). Such developments, Giddens argues, have generated “ontological insecurity”; feelings of anxiety and insecurity amongst members of society (1991). The negative emotional response of ontological insecurity, and the anxiety which it produces, motivate us to attempt to reduce them. Attempts to remove or reduce uncertainty; of managing risks; help us to obtain stability in our lives. According to Giddens, risk as a concept becomes a means of identifying, calculating and, ultimately, reducing the uncertainty.

Beck and Giddens both point to the primacy of risk and risk management in a world experienced as increasingly riskier and more uncertain than before. Risk avoidance can demonstrate an individual’s moral worth to an extent. According to Tulloch and Lupton (2003), the avoidance of risk draws on the ideal of the “civilised” body, control over one’s life, self and body regulation, to “avoid the vicissitudes of fate” (2003:113). Risk avoidance on behalf of one’s children can be particularly associated with being a “good” parent, yet mothering can be a “fraught business” as Kemshall argues (2003:3), citing an article in the *Daily Telegraph* which refers to the “plethora of risks” mothers face, “from risks to newborn babies from their mother’s kisses, to vaccines, cot death, food risks and paedophile abductions en route to school”. This plethora of ever-changing risks has led to increasing distrust of both science and progress and traditional voices of ‘expertise’ may be challenged. Many parents’ rejection of the MMR vaccines for their children illustrates how experts’ knowledge of risk has been directly challenged in the recent past. When parents distrust traditional “professional” voices of expertise in this manner, their management of risk in relation to their children’s health becomes an individualised project (Kelley et al. 1998: 24). Indeed, as demonstrated earlier in this chapter by Robinson and colleagues, parents have also challenged and at times rejected the risk SHS poses to their children (Robinson et al, 2007a), demonstrating how resistant discourses are constructed when understandings based on personal experience and observation contradict expert discourses. Rather than passively receiving and

accepting expert information, people assess it in different, and sometimes sceptical, ways (Douglas, 1994). Attributing blame to others is central to the ways in which people respond to risks and uncertainty, Douglas argues, creating ‘negative communities of interest’ within society (Douglas, 1992).

2.9.2 Risk and culture

The risk society thesis is widely applied in the social sciences, yet has been critiqued for the notion that the relationship between risk and culture is a feature particular to contemporary, late-modern life. This stance is problematic as it does not encompass variation in risk perceptions and responses within groups and between individuals. While in later writings, Beck concedes that risk is indeed socially constructed and that it is “cultural perception and definition that constitutes risk” (Beck, 2000:213); the construction of risk in the risk society thesis is problematic as it de-contextualises and de-socialises risk (Douglas and Wildavsky, 1982). The risk society thesis also portrays risk avoidance as rational behaviour, while risk-taking is represented as irrational, ignorant and/or irresponsible (Lupton, 1999, Tulloch and Lupton, 2003). In her critique of this view, the anthropologist Mary Douglas (1992: p. 13) has stated: “We are said to be risk-averse, but, alas, so inefficient in handling information that we are unintentional risk-takers; basically we are fools.” Douglas points out that risk perceptions are different *across* a range of social and cultural systems. Contrary to Giddens, Douglas argues that risk aversion is not an inherent or in any way “natural” response to uncertainty in contemporary life. Rather, “When uncertainty is at a very high level and everyone is taking big risks, the cultural norms will encourage more risk-seeking” (Douglas, 1986: 75). For example, in the 1980s the UK and US, enterprise culture placed great value on taking high risks (venture capitalism).

The question of acceptable standards of risk is inextricably linked to acceptable standards of living and morality, which vary across contemporary as well as past societies, and must therefore be analysed within the particular cultural system in which the other standards are formed (Douglas, 1986: 82). Douglas proposes that while some risks are given more attention, others are downplayed and ignored,

according to the particular culture and its values (Douglas 1992). Those that tend to be ignored are those encountered frequently in everyday life (in addition to those encountered very seldom). Screening and ignoring common everyday risks in this manner makes one's immediate world appear safer than it is (Douglas, 1985:30) and presumably, protects against a constant sense of uncertainty and alarm.

According to Douglas and Wildavsky, risk is not an individual but a collective construct (1982). The model of the process by which a shared moral stance influences risk responses and acceptability is through the "group-grid" (Douglas and Wildavsky, 1982). The grid concept refers to the extent to which the group requires conformity to the norms, identities and practices by its members. Conformity by individuals is more likely in stronger, more cohesive and established groups which often demand a higher level of adherence. The group-grid also limits the range of alternative responses to risk that are available according to the values and morality shared by the group (Douglas and Wildavsky, 1982).

In the group-grid perspective views of risk are "culturally shared" experiences (Douglas 1992: 44). Individuals' collective lifestyle, group membership and cultural identity act as a filter, screening claims to truth and deeming some more reliable than others depending on the extent to which they are consonant with the morality adhered to by the group. This is illustrated in a study of smoking practices in the workplace (Bellaby, 1999). The smoking patterns of NHS staff were compared with workers at a food processing plant and found the risks of smoking to be highlighted much more amongst NHS staff. The perception that they were expected to "set an example" to the general population and refrain from smoking resulted in lower levels of smoking found amongst its members. It is, of course, also possible that NHS staff were more aware (and daily exposed) to the consequences of smoking, working with ill people.

Taking risks can also be instrumental to self and group-identity. Studies of young people's use of alcohol and tobacco (Denscombe, 2001) have certainly demonstrated how risk can be perceived as a means to move from childhood to adulthood when young people can use the risks associated with smoking as a marker of such a move.

In a study on the pleasures and benefits of risk-taking, Lupton and Tulloch's participants talked about certain risk-taking as challenging oneself in order to self-improve, emotionally engage in extending oneself beyond the strictures of culture and society, and to exercise control over one's emotions and bodily responses (2003). Risk-taking is seen to contribute to self-development, self-actualisation and self-control and is part of a wider discourse that privileges the self as something requiring constant work (Tulloch and Lupton, 2003: 122). The uncertainty risk entails is described as both dangerous and exciting. In some of these accounts, the ideal of rational risk avoidance is substituted for an ideal self that involves the heightened embodiment fear and anxiety produces when encountering risks. Rather than avoiding risk, there is an excitement generated by these feelings while temporarily doing risky things and losing control. For others, risk-taking leads to a greater sense of control as risks could be confronted and overcome rather than avoided, resulting in a feeling of accomplishment. Tulloch and Lupton argue that risk-taking can therefore be voluntary and based on knowledge of oneself and one's capacities rather than based on ignorance (2003:123).

The group-grid approach has also been subject to critique by scholars for both oversimplifying and disenfranchising the individual and their relationship to the peer groups (Shrader-Frechette, 1997, Lupton, 1999). Rather than the group grid determining the individual's risk perceptions, people actively seek out and select social groups with similar orientations to them. Furthermore, individuals often belong to more than one group (Shrader-Frechette, 1997). Group membership may therefore construct the individual's perception of risk or reflect it, or indeed both.

Douglas offers a sophisticated and detailed thesis of the role risk and anxiety plays in social life, yet the group-grid model is thus somewhat reductionalist and could be nuanced further. It is not only between cultures and groups that individuals may respond to and view risk differently, as suggested by Douglas' model, but the same individual may respond differently to risk in different situations. What may appear dangerous in one micro-social situation may not in another (Schutz, 1970). For instance, in his study of male prostitution in Glasgow, Bloor argues that the risk of HIV infection is constructed very differently by sex workers in their professional and

private sexual encounters (1995). While they report barrier contraceptive methods are highly relevant in professional sexual encounters, they are often perceived a lot less so in private encounters. The interpretation of risk depends on individuals' "stock of knowledge at hand", an idea Schutz explains as being based on habitual knowledge that is "dormant, neutralised, but ready at any time to be reactivated" (Schutz, 1970: 66).

Similarly to Schutz, Goffman sees the individual's perception and orientations towards risk as something dynamic and ever-changing through everyday social encounters. Rather than a static entity, an individual's approach to risk depends on others' definitions of the situation based on wider cultural values that surround them as well as the specifics of the physical environment in which the interaction occurs. In dramaturgical theory, social behaviour is framed as a wish to portray a positive sense of self to others (Goffman, 1959). Individuals not only negotiate their way through interaction to maintain their own performance but also (to varying extents) the performances of others.

Goffman's notion of "face", which he defines as "the positive social value a person effectively claims for himself by the line others assume he has taken during a particular contact" (Goffman 1972: 319), is particularly relevant to risk. Whether face is granted is dependent on a given social group's evaluation of the individual's way of expressing his view of the situation (Goffman 1972: 319). Face has to be actively achieved and maintained through social interaction in a process Goffman defines as "face-work". This is highly relevant to the way in which participants present themselves and their risk taking and avoidance within interviews. As Baruch (1981) argues, parents' narratives of their children's experiences of ill-health are characterised by their desire to, "accomplish the status of moral adequacy" (Baruch 1981: 276).

2.9.3 Children and risk

Children are subjected to more surveillance and social regulation than ever before. In the risk society (Beck, 1992), parents increasingly identify the world outside the

home as one against which their children must be shielded and in relation to which they must devise strategies of risk reduction (James et al. 1998: 7) The best means of keeping children safe is often a highly ambiguous and contentious topic, both within and outside of the family. Indeed, Valentine and McKendrick (1997) found a number of parents in her research reported feeling under pressure from other parents, to treat their children as less competent and more vulnerable than they actually perceived them to be with those who did not conform to a very protective norm reporting they were stigmatised by other parents (Valentine and McKendrick, 1997: 227).

In line with Childhood Studies (reviewed in Chapter 3), research has also sought to show that children are not passive recipients of regulation imposed by safety-conscious parents, but actively resist and negotiate this regulation to preserve a feeling of autonomy (Tomanovic, 2003: 51). Children often saw parental control as simultaneously protective and constraining (Kelley et al, 1998). The one-sided focus on children as risk-takers and parents as trying to protect them from such risks renders children's strategies to manage risk in their everyday life relatively unexplored (Christensen and Mikkelsen, 2008).

By contrast, children's accounts of their strategies to *manage* the risks they encounter has also been explored in a small body of research that has explored and contrasted parents' and children's intergenerational 'risk landscapes' (Backett-Milburn and Harden, 2004, Christensen and Mikkelsen, 2008, Kelley et al, 1998, Scott et al, 1998). For example, Kelley et al found that young people were very conscious of risk, identifying a number of potentially dangerous areas and times of the day, providing accounts of their own strategies for reducing such risks (1998). Children's experiences of their own body and its capacities are central to engaging with risk, according to Christensen and Mikkelsen (2008:117), who found some of their participants' belief in their level of skill on a bicycle made wearing a helmet unnecessary, for example. Overall, two important themes emerge in children's accounts: the moral content in the importance of assigning responsibility and guilt; and the importance of risk-taking and management in creating children's social identity as autonomous, responsible selves (Christensen and Mikkelsen, 2008:114). Risk management is therefore an important "technology of the self", both for

children and adults, according to Kelley et al (1998). According to Green, risk management is “an irresistible technique, for to claim individual responsibility for managing risks is also to claim maturity as a decision-making actor” (1997:475), one that has implications both for individual and group identities as risk management was used to delineate group boundaries (Green, 1997). As such, the issue of responsibility for risk management can be seen as an especially pertinent issue for young people who are increasingly expected to display the qualities of competent and independent adults.

The management and avoidance of, or engagement with, risk can serve similar purposes. Where parents are expected to protect children from risk, we can also see that children wish to manage risks to portray themselves as responsible and mature. Cultural norms regarding risk behaviour, and what is considered a risk, are also important and we have seen that the same risk can be constructed differently in different situations. Risk is thus, evidently, a complex entity dependent on culture, the individual circumstances and the context within which it is encountered. With each culture having its own stance toward knowledge, truth is not on offer, not even from science (Douglas, 1992: 32).

Whether a situation or event will be seen as risky, avoided or engaged with, thus depends on the capacity that individual(s) involved feel they have, whether it fits with their culture and “stock of knowledge in hand”. If it does not, expert notions of risk may be resisted. If there is uncertainty, accountability may be opted out of. A risk is not judged on its own, but by comparing other risks faced in everyday life with some fading and others taking a prominent position. While from a different cultural group-grid perspective where the risk is seen to be prominent, the morality of those who engage in risky behaviours despite expert warnings may be judged irresponsible, even immoral, and come to be stigmatised as we have seen in the case of smoking and smoking around children in particular. While risk theory has informed a number of studies, some of which have been outlined here, how children assess SHS risk and whether, for example, “expert” constructions of SHS risk is also contested by children is not known. Risk theory is highly relevant to this thesis and I will draw on this discussion in relation to the findings of this thesis in the data and

discussion chapters.

2.10 Conclusion

This chapter has outlined how other people's smoke came to be viewed as a risk to health, particularly child health, and has provided a review of relevant theories of risk. The past decade has seen SHS subject to regular features in the media, a large and rapidly growing research field and the main reason for the strictest tobacco control measure to date: outlawing smoking in enclosed public places. The attention SHS has received, particularly the smokefree legislation, has led to impressive public health gains in a short space of time.

The success of this and other preceding tobacco control activity have reduced smoking prevalence across the Minority world, so much so that it has sparked discussions about the "end game" in recent issues of the journal *Tobacco Control* (for example, Malone, 2010, Thomson, Edwards, Wilson and Blakely, 2012). The tobacco "end game" refers to the mid- to long-term goal of not just reducing tobacco consumption but to eliminate it and achieve a close to zero smoking prevalence (Malone, 2010). Despite the many successes of tobacco control measures that this chapter has outlined, such discussions still appear ambitious and perhaps a little premature given 40% of children still estimated to be exposed to SHS globally (Oberg et al, 2011). Tobacco control measures have also had a number of negative consequences, such as an increased stigmatisation of people who smoke, perhaps particularly parents who smoke. A moral element has always been implicit in some tobacco control discourse but it has been made explicit with the discovery that smoking affects others in addition to the person smoking. Disadvantaged mothers who smoke and their children are a particular focus of research and interventions for understandable reasons, yet this focus can also serve to underscore a responsibility/irresponsibility and smoking discourse which may be both ineffective, as it may make people who smoke less willing to access cessation services, and unethical in compounding the stigma for an already stigmatised group.

This review has highlighted the scarcity of social scientific research and commentary up until recently and how social scientific research with child participants, with a few notable exceptions, remains so. Quantitative and adult perspectives currently dominate the evidence base around SHS risk perception, smoking in the home and car. While the evidence base has illustrated the importance of the issue and set the parameters in terms of frequency and extent, many details are still missing. By their very nature, large-scale surveys can tell us very little about the social context and family dynamics surrounding SHS and tend to address adult rather than child views. Much current research has also framed children as the passive and voice-less objects of concern rather than social agents by excluding them. Some approaches taken appear limiting and focused on mother's roles on the expense not only of children's role in family interaction around smoking, but also of the roles played by fathers and grandparents. Social scientific work has demonstrated the importance of accounting for the social context but seldom focuses on children's own perspectives.

Intervention studies, and reviews of these, testify to the potential to intervene to reduce children's SHS exposure in the home, but also to the considerable uncertainty on effective ways of doing so. Some of this uncertainty could be attributed to our limited understanding of what occurs in families and in the home, where and when people smoke, and the measures they take to protect children from SHS exposure. Our understanding of children's perspectives has been advanced by two large studies reviewed here. Based on these, we know many children dislike smoking and SHS and draw on addiction and coping discourses to explain why people might smoke. Yet, little, if any, current in-depth information on what children think about smoking in the home and car, if and how they negotiate smoking restrictions and how and if these change for children from areas of contrasting socioeconomic profile exists. Such information can potentially help advance research, practice and policy in this important field for tobacco control and child health.

Existing literature regarding factors and issues involved in smoking practices in the home and car offers a useful starting point where a more sociological and child orientated perspective can inform our understanding. For example, important work has been conducted with adult participants, and one in the same communities I

recruited from (Martin et al, 2008). Many gaps remain in our understanding of the issues that matter in the establishment and maintenance of smoking restrictions in private settings. Qualitative contributions have illuminated some of the processes that underlie many restrictions, particularly their social nature. Blake Poland has identified relative power as being a key element to exploring the why and how of smoking behaviours (2006). With the uneven power distribution in many child and parent relationships it is likely that power is even more important in explaining child and parent interactions around smoking restrictions in the home. In a general sense, the study this thesis describes will contribute towards addressing the gap in current literature on children's perspectives of SHS and their views on the risk it is said to entail. More specifically, the study this thesis describes will contribute towards addressing the limitation in understanding the relational and power aspect of child and parent relationships as they relate to context-bound and collective understandings of risk and negotiations of smoking in the home and car.

Chapter 3: Childhood Studies

3.1. Introduction

This chapter introduces and critically engages with the field of Childhood Studies, the overall perspective that informs this study (a perspective not attributable to one scholar or text but a key early text is James and Prout, 1990). Referring to studies of the meaning and experience of being a child, it has become *the* approach for studies researching the experiences of children. It counters many of the assumptions imbedded in research, policy and practice which view children as objects of study and concern and, instead, underlines children's active social roles and agency. Scholars informed by Childhood Studies have investigated children and young people's views and experiences of a wide range of issues that concern them, including friendship and its meaning for young children (Corsaro, 1997), the varied roles that children take on in family life in different parts of the world (Punch 2001), children's experiences on the street (Scheper-Hughes and Hoffman 1998), and what children think about their brains (Singh, 2012) for example. Methods vary but there is an attention both to the inherent power and ethical asymmetry of the child participant and adult researcher relationship in the research process.

As established in previous chapters, smoking in the home and car is a relatively new area of research and children's views and experiences remain largely unexplored within it. A Childhood Studies approach contrasts with the way in which research with children have been conducted so far in the SHS literature but is well placed and potentially valuable to inform this study of children's active roles in family negotiations of smoking in the home and car. In turn, the findings of this study may also contribute to the current debate within Childhood Studies around children's agency and voices, a debate discussed in this chapter. The chapter begins by outlining the origins of Childhood Studies, proceeds to discuss the central tenets of the approach, including children's voices, and the criticisms leveled at them. The chapter ends with a discussion of a central concept to both Childhood Studies and

this thesis – child agency – in order to frame the discussion of findings later in this thesis.

3.2 The rise of Childhood Studies

Philippe Aries's historical account of the conception of childhood, *Centuries of Childhood* (1962), argued that although children have, of course, always existed, the concept of childhood belongs to modern society and is a product of historical and social processes. In arguing that beliefs and attitudes towards children have evolved over time subject to economic and social change, he was amongst the first to recognise childhood as something that has not always been viewed as a particular phase of the life course but has been socially constructed as such.

The term 'constructionism' has reverberated across the social sciences since the 1960s. It is now so commonplace that the term 'constructionist' has become almost meaningless as it is in danger of encompassing "both everything and nothing at the same time" (Gubrium and Holstein, 2008:5). There are a variety of conceptual positions within constructionism, too many to outline here (see Holstein and Gubrium, 2008, for a detailed overview). The perspective of social construction adopted in this thesis is guided by the seminal work of Berger and Luckman (1966), who take a mid-point on the scale of social constructionism. Rather than a realist (the world is there for us to uncover) or 'pure' constructionist (there is no reality as such) viewpoint, they argue that while there is an external 'real' world we only know of this world through our socially-constructed meanings.

Whatever the stance, research conducted in a constructionist vein highlights that social reality has dynamic contours and is actively assembled and assigned meaning by people (Gubrium and Holstein, 2008). Shared meanings of social reality are constructed within social interactions and maintained by social practices (Gubrium and Holstein, 2008). Such shared meanings are internalised through the process of socialisation, and individual choices that are deemed feasible are constrained by the cultural and social context of the individual and, arguably, their "group-grid" (Douglas and Wildavsky, 1982, discussed in chapter 2). In chapter 2, the concept of

risk was shown to differ across space and time; to be socially constructed.

Similarly to class, gender and ethnicity, childhood is also a social construction defined and constructed in processes of social action. It is not a social fact or historical constant but differs across cultures and changes with time. Aries' central claim is that while children were not "neglected, forsaken or despised", the idea of childhood did not exist in medieval society (1962, p 128). In other words, he claimed that the distinction between adult and child did not exist beyond the time that children could cope without the constant attention of adults. Another historian of childhood, Lloyd DeMause (1974), claims that children were subject to abuse and mistreatment in medieval times to become gradually better cared for and nurtured by parents today (albeit not all, of course). Aries' and DeMause' theses are primarily based on the portrayal of children as little adults in medieval art, religious artefacts, advice literature, letters and certain diary entries. In her book, *Forgotten Children*, (1983), the historian Linda Pollock challenged the indirect and selective nature of the historical sources that historians like Aries based their analyses on. When systematically examining more direct sources such as diaries, autobiographies and newspaper reports of child abuse cases, she proposes a view that the parent and child relationship is remarkably similar and constant in childhood throughout different times. She presents evidence from her systematic analysis of 500 British and American sources that children were valued and precious to their parents just like today so parental care for children is a historical constant. Stating that parents have "always tried to do what is best for their children within the context of their culture" (1983:64), she posits that parental love, protection and socialisation are a historical constant. This statement made Horn retort, "To youngsters harshly disciplined ... it was doubtless small consolation to know this was taking place within the context of culture" (1998, p 46, quoted in Corsaro, 2011). As highlighted by a number of authors (Corsaro, 2011, Gillis, 1985), Pollock outlines rather than develops her thesis of the constant nature of parental love and attempts at doing the best for their children and it remains unclear how she would make this statement with such conviction. Further, and despite Pollock's detailed analysis of the diaries and autobiographies, such sources are, of course, also selective accounts, both in terms of what the writer chose to record and the middle (even upper middle) class they were

likely to belong to. Her sources thus share some of the weaknesses of Aries' art sources (Corsaro, 2011), but I shall return to the constant nature of parental care for children in the concluding chapter of this thesis.

Nevertheless, Pollock set the stage for later accounts of childhood within both the new history of childhood and Childhood Studies by seeing an interactive parent and child relationship where parents were not only influencing children but children influenced parents. Aries' social constructionist approach and Pollock's recognition of children's and parents reciprocal relationships leave an important legacy still central to Childhood Studies today. However, even in their addressing of the neglected role of children in historical record, their focus is on adult conceptualisations of children rather than children as active social agents. This is the focus of the new history of childhood as well as the new sociology of childhood.

The new sociology of childhood emerged in the 1980s to take hold in the 1990s. Given similar approaches and concerns were also emerging in other disciplines, from education and children's geographies to law, the phrase "Childhood Studies" is now considered more reflective of this cross-disciplinary perspective than one aligned specifically with sociology. In their seminal text, *Constructing and Reconstructing Childhood* (1990) Allison James and Alan Prout spelled out its ontological and epistemological stance drawing on work from disciplines including psychology and anthropology in addition to sociological work. Children are active agents rather than passive recipients in all processes that affect their lives and, as importantly, there is a normative orientation that they *should* be. Childhood Studies is a critique of how children and childhood itself is theorised and researched, particularly (but not exclusively) in developmental psychology. Countering some aspects of developmental psychology, Childhood Studies opposes a dichotomous construction of children as incompetent in relation to competent adults with views, logic and reason. Adulthood was the norm against which childhood had been assessed, resulting in children being viewed as incomplete human "becomings" rather than beings (Qvortrup, 1994) and the ensuing exclusion of children as equal members of society:

... the maybe unintended message, which seems to indicate that children are not members or at least not integrated members of society. This attitude, while perceiving childhood as a moratorium and a preparatory phase, thus confirms postulates about children as “naturally” incompetent and incapable. (Qvortrup, 1994:3)

For instance, the work of Swiss developmental psychologist Jean Piaget (in Mussen, 1983) on the stages of child cognitive development has been singled out to exemplify the developmental view of children as incompetents who gradually become competent adults in a process of stages of increased competency and reason. In Piaget's studies, children's cognitive development is assessed with tasks such as conservation tasks that hinge on the understanding that the amount and quantity of a matter such as water, stays the same regardless of a change to the shape of the container it is stored in. In a seminal study by another developmental psychologist, Margaret Donaldson, she demonstrated that by making tasks more meaningful in an everyday context to children, their abilities far exceeded those predicted by Piaget (1982). Accordingly, the abstract nature of Piaget's tasks meant children's cognitive development and skills have been underestimated.

James, Jenks and Prout directed particularly strong critique of Piaget's model of developmental psychology and the framing of children as incomplete and incompetent and for its decontextualised and universal developmental stages (James et al 1998, p.18). While Piaget's tasks could be critiqued in this manner, as children who gradually acquire reason and logic to become complete adults, Piaget's theory also describes and values children's own ways of thinking and active attempts to master their worlds. As such, Piaget held a *constructivist* and active model of socialisation. As Woodhead (2009) writes, some scholars have caricatured Piaget's work, failing to incorporate the full range of his theories and focusing more on the imperialism of those using Piaget (for example, in education) than his actual research.

Proponents of Childhood Studies have also critiqued functionalist models of socialisation. Talcott Parsons positioned that children develop and internalise norms and values from their family, peers and society (Parsons and Bales, 1955). According to Parsons' functionalist model of socialisation, a child is like a “pebble” thrown into

the social pond (Parsons and Bales, 1955:36-37) with the first ripples of the water, or primary socialisation, occurring when a child is developing personality characteristics, attitudes and beliefs based on their family and their parents in the family home. In this way, Parsons argues, children internalise society. Later reproductive models of socialisation refined the functionalist perspective by recognising inequalities, highlighting the advantages to children of those with greater access to cultural resources enjoyed both in their access to them, and their treatment within the educational system, for example (Bernstein, 1981, Bordieu and Passeron, 1977).

Such socialisation models posit childhood as preparation for adulthood, a time when inability and incompetence is expected and rationality and competence is something that children gradually acquire. Interactionist perspectives, which inform Childhood Studies, challenge the passive manner by which children supposedly become socialised and instead propose that individuals make a difference to what happens, to decisions and to their own and others' lives. Instead of just internalising the society they are born into they act upon society and can change it (Prout and James, 1990).

More specifically, scholars within Childhood Studies criticise the manner in which so-called Piagetian and Parsonian perspectives juxtapose the competencies and rationality of children and adults. Implicitly positioning the child as "*a defective form of adult, social only in their future potential not in their present being*" (James, Jenks and Prout 1998: 6), Childhood Studies instead sees children as agents capable of influencing their environment and valuable in the present. Further, Alanen proposes that the social and historical construction of childhood means it is "always political" (Alanen, 2011). It is a critique of the ways in which children have been undervalued in society and the ways in which their lives are organized and regulated. Empirical work informed by Childhood Studies aims not just to represent the neglected perspectives of children to improve understandings of different issues but to improve the everyday lives and social standing of children. Like the topic of this thesis, research with child participants is often related to issues of child health and their rights to be heard; that they *should* be heard.

Ideas regarding the agency of children and their rights to be heard have policy ramifications. Much is shared by children in all societies including a difference from, and subordination to, adults, the need for protection and an adult responsibility for children. Such commonalities vary across time and space but they allow us to see children as a social group in relation to adults with rights sometimes, and certainly historically, neglected, like women are to men or socioeconomically disadvantaged are to advantaged groups.

Indeed, Childhood Studies and its concerns have coincided with the modern children's rights movement that shares the emphasis on the value of children, their agency and rights to participation. In 1998, Michael Freeman called for more dialogue between the Childhood Studies and the children's rights movement, highlighting the common ground they share (Freeman, 1998). Since then, references to the "rights" of children have become more frequent, if still lower than might be expected, considering the commitment of Children Studies scholars to the improvement of children's lives (Alanen, 2011:6). Like Chapter 1 of this thesis, writings about research with children frequently make references to the United Nations Convention on the Rights of the Child (UNCRC). Passed by the UN in 1989, the CRC encode children's rights of participation, protection and provision in 54 articles. While protection and provision have long been considered to be the right of children (for example in the Geneva Declaration of the Rights of the Child in 1924 and 1959), the UNCRC is different in also emphasizing the rights of participation and of children's views. For instance, Article 12, which sets out the importance of respect for children's views and their rights to say what they think in all matters affecting them, and to have their views taken seriously, is often used as one of the reasons to research children's lives and views.

The UNCRC has been passed by all countries in the UN (except the US and Somalia) which makes it the most widely ratified human rights instrument in history. Ratification does not necessarily equate impact, however, and the UNCRC has been criticised for being more about rhetoric than reality, "aspirational" (Payne, 2009: 150) with a distinct lack of teeth should countries not follow the articles (Tisdall, 2012). Further critique highlights that it may impose Minority world views of children onto the Majority world where local cultures may not support the idea of children being active and demanding of their rights (Valentine and Meinert, 2009).

Recently, scholars within Childhood Studies have begun to refer to the first and second "phase" of Childhood Studies (Tisdall and Punch, 2012) to mark a development of the approach. Early empirical work that inspired Childhood Studies demonstrated children's knowledge, competencies and agency. For example, in Bluebond-Laugner's US study of children in an oncology ward, participants

delivered powerful accounts of how they read subtle cues from adults (who attempt to protect them from this knowledge) that they are dying (1978). Perhaps the most influential early empirical work within Childhood Studies, however, is Corsaro's ethnographic study of 3- to 4-year-olds' peer social interactions (1978). Based on an ethnographical study of a nursery school, it focused directly on sociolinguistic analyses of videotaped social and communicative interaction between the children. In identifying features of peer culture within a nursery, such as status, roles, norms and friendship, the importance of interpreting children's behavior from their own rather than an adult's perspective is clear. This study provided a rich account of socialization where culture and language are transmitted between children as opposed to the Parsonian adult to child version. It should be noted that Judy Dunn's work within developmental psychology supported Corsaro's findings about the active part young children play in their own socialisation. Her observational/interview study of very young (aged 1 to 3) children's involvement in family life and their socio-emotional development demonstrated the local culture of the family and the important and active role children played in it (Dunn, 1988).

Around the same time, Gary Fine published *With the Boys*, also an ethnographic study, exploring how boys become socialized to men through participation in organised sports (1987). Drawing on three years of observation of five American Little League baseball clubs, Fine's account of how boys learn to play, work, and generally be socialised into a male gender role through organized sport and its accompanying activities, again countering the idea that children are only socialised by contact with adults without their own roles and subcultures within that process.

Such work illustrates how children create subcultures that adopt and reject different adult rules and place children, and their agency, in focus. Corsaro's work is particularly strongly associated with contemporary Childhood Studies as he emphasised hearing children's voices and gives weight to their own meaning making. He demonstrated that even very young children contribute to their own socialization and affect adults and are not just affected by them (1978).

Inspired by such work, the first phase of Childhood Studies saw the establishment of

what is commonly referred to as its six central tenets (James and Prout, 1997b), while the second phase sees many of these critiqued. As discussed, the first tenet is that childhood is *socially constructed*, a culturally and socially produced entity that varies across cultures and history rather than being identical across time and space (Aries, 1973). The second tenet states that childhood is a *social variable*, like gender, class or ethnicity. Rather than treating children as a group with the same needs, wants and abilities, an acknowledgement of variation across space and time is required. The third tenet is that children are worthy of study in their own right, not merely as “adults in the making” or human becomings but as human *beings* (Qvortrup, 1994). Fourth, children are competent *social actors*, who shape their social worlds. There has been a tendency of adults (including social science researchers) to presume that children are incompetent, passive and powerless. Instead, Childhood Studies advocates that we start with the assumption that children are competent. Fifth, the presumed competence of children means that they should be involved in shaping the research in which they take part. *Participatory* approaches to research are seen to encourage children to influence the outcomes of research, and give them a prominent and vocal presence in the data produced. Finally, *reflexivity* about the ways in which social science researchers’ work contributes to the construction of childhood and how children should be treated is encouraged. This entails a strict adherence and attention to ethical practices for those who research the views and experiences of children.

Childhood Studies has had an extraordinary impact on the position of children in social science research. While children have always been the focus of disciplines such as paediatrics, education and developmental psychology, children were predominantly absent, featured indirectly or a secondary concern in much social science research prior to the 1980s (Shanahan, 2007). There has been an explosion of work in the last three decades professing allegiance to Childhood Studies, as revealed by a cursory glance through any recent academic journals (journals which have themselves emerged from this paradigm shift) such as *Children’s Geographies*, *Childhood*, and *Children & Society*. Such articles usually contain a statement of the Childhood Studies “formula”, comprised of three well-rehearsed key components, or “mantras” (Tisdall and Punch, 2012) arising from the six central tenets outlined

earlier: the *social construction* of childhood, a focus on children as *active social agents* and the *intrinsic value of the child voice/participation*. The mantras often signify studies with child participants who demonstrate their competence and/or knowledge in some manner. Yet, as Chapter 2 testifies, ideas from Childhood Studies have had less impact on public health literature more broadly and have gained very little purchase within the literature on smoking in the home. Instead, much epidemiological, health promotion and tobacco control literature implicitly positions children as the passive victims of parents' smoking practices by neglecting to examine their perspectives and roles within them.

The rise of Childhood Studies has both altered and is in itself a reflection of the altered status of children in society. Vigorously critical of what has gone before, Childhood Studies has been less forthcoming to challenge its own assumptions, perhaps, as Kay Tisdall argues, because in its efforts to establish itself it created a sensitivity to critique (Tisdall 2012). Certainly, few would question the importance of Childhood Studies' contribution in beginning to alter perspectives of children and childhood with its attention to agency and rights. Recently, however, several of Childhood Studies' central tenets have been challenged to some extent. The chapter now turns to such challenges.

3.3 Challenging Childhood Studies

Recently, Childhood Studies has been subject of much critique from both outside of and within its own "ranks". Primarily, this critique centres on a lack of nuance in constructions of children as beings and children as similar across the world. Children's voices and participation in research as inherently good have also been challenged. Similarly, the idea of agency and power as an attribute or something to be possessed has been questioned (Tisdall, 2012, Tisdall and Punch, 2012, James, 2010). These debates are important to engage in if we are to develop conceptual understandings applicable across different societies (Gallacher and Gallagher 2008, Vanderbeck 2008, James 2010, Plows, 2012) and the following sections attend to these debates in turn. Child agency and the way in which this agency is conceptualised is a key part of such critiques (Gallacher and Gallagher 2008, Alanen

2010, Plows, 2012), therefore the last section will examine this debate in more detail with reference to two studies of child agency.

3.3.1 Children as beings

Childhood Studies holds that children are worthy of study in their own right, independent of adults. This does not mean that children should necessarily be seen outside of, or apart from, their relationships with adults. Rather, they are not to be seen merely as “adults in the making” or human becomings, subordinated to adults. Just how different children are from adults has been the subject of much debate (Punch, 2002). Childhood is not just culturally and socially constructed but by its very definition, transitional. Important changes occur throughout childhood in physical size but also in emotional maturity, relationships, identities, skills, activities and perspectives. Developmental psychology remains pertinent in studying such changes especially if considering different socioeconomic and cultural contexts (Woodhead 2009). Nevertheless, it remains that the sort of developmental tests Piaget employed may (albeit unintentionally) promote a view of children as lacking and incomplete compared to adults. So the question is how to balance the being and becoming aspects of children.

However, Lee has expressed concerns about the philosophical basis of the idea of either children *or* adults as complete beings (2001). Lee argues this to be a simplistic distinction because both children and adults could more accurately be described as becomings. Adults have often not achieved much stability in terms of their working lives and relationships and are often in transition just like children. With adults as human becomings, then children are, equally, in this “age of uncertainty” (2001:19). Rather than viewing a “becoming” state as something of less value, the idea of children as “becoming” beings has recently gained favour because “becoming” and immaturity can be seen as valuable attributes of human existence (Prout, 2005; Gallacher and Gallagher, 2008; Uprichard, 2010). For instance, when discussing whether different research methods are suitable for children and adults, Thomson argues that both children and adults may need flexibility in approaches, not because of their age, but because they may have different preferences, concentration spans or

a marginalised status (2007). Generally, however, proponents of Childhood Studies would argue for starting with the assumption that children, like adults, “can do it unless proven otherwise.” (Matthews, 2003)

As an heuristic device, child/adult dichotomies may be of value, however. While such binary categories may be simplistic, they also enable comparison (James, 2010, p. 490). Children and adults, as groups, have different constraints. However, by drawing such a distinct line between where childhood ends and adulthood begins does not represent the complexity or continuum of childhood (James, 2010).

3.3.2 Children’s voices as inherently good

Much writing within Childhood Studies strongly approve and promote the child “voice” as inherently positive. Many studies are qualitative and present direct quotations from children, illustrating the value of children’s voices. Yet the selection of such quotes, and the framing and analysis of them, is almost always the work of adult researchers. In Tisdall’s words: “*Researchers are determining what counts as a ‘voice’, often representing that ‘voice’ textually and interpreting what that ‘voice’ might be saying*” (2012). She argues the privileging of text over other forms of communication, by translating, for example, drawing, role-play and observation into text for analysis and presentation is unfortunate when such work could be analysed on its own merits (2012). However, in avoiding the “translation” into text of photographs or drawings in reports of findings not “translated” into text, it is difficult to see how a reader would interpret data without either context or the analytic skills to interpret a drawing, for example.

That “voice” is *always* a good thing, has also been problematised on the basis that it may discount children who can’t or won’t speak (Tisdall, 2012, Lewis, 2010). Prioritising verbal utterances over other forms of communication also risks excluding children and young people who are silent, laugh, or pull faces in response to interview questions (Nairn, Munro and Smith, 2005, Lewis, 2010). Valuing voices may come at the expense of disregarding and devaluing silence, as Lewis argues. She puts forward a convincing case not only for recognizing silence but also for

noting, responding to, interpreting and reporting it in research (2010). Silence is often ignored and unreported in research accounts or given as an example of a lack of rapport or sensitivity on the researcher's behalf, yet silences can be used for many different purposes important to account for – for example to avoid the risk of losing peer capital (as described in Goldstein, 2007) – leading Lewis to propose that “silence may be more informative than voice” (2010:17).

However, Lewis does not reflect on the complexity of interpreting silence. Because there is (literally) nothing in the silence itself to interpret apart from its duration and the body language accompanying it, one would have to rely on the contextual cues and the preceding utterances. Given the infinite number of reasons to remain silent in an interview situation – including miscomprehension, withdrawal of consent, the topic, lack of rapport with the interviewer, the question, what had just been said, what others had said, shyness – it is perhaps more open to misinterpretation than a statement which gives the analyst a certain frame of reference.

Silence can be an act of power. Rather than as an act of passivity or incompetence, it can demonstrate agency as much (or even more than) responding to all questions or requests. In an ethnographic Swedish study of children at two nurseries, silence was one of the strategies nursery children between the age of one and six used to negotiate adult-imposed spatial and temporal boundaries (Markstrom and Hallden, 2008). Examining instances of agency where children questioned or opposed the social order in the nurseries, they found silence was a strategy alongside others such as avoidance, negotiation, collaboration and partial acceptance. They provide data of a nursery teacher who asks a small boy to participate in a game with all the other children and he responds by refusing to engage with her and moving out of her reach underneath a table. A lack of verbal response meant he took ownership of his own time and space so it was clearly an act of agency.

Children's silence in interaction could be interpreted as interactional competence, rather than incompetence as it may more commonly be (mis)understood (Markstrom and Hallden, 2008).

3.3.3 Participatory research as inherently good

The presumed competence of children has often been taken to suggest that they should be involved in shaping the research in which they take part in ways that extends the usual role of a research participant. The approach promoted entails a genuine exchange between researchers and children and giving them a prominent and vocal presence in the data produced. The “children’s rights” agenda (Freeman, 2007), Article 12 of the UNCRC in particular, gives political impetus to research that directly engages children not only in asking their opinions but in involving them in the research design, process and dissemination. Consequently, more or less participatory approaches are often chosen in research informed by Childhood Studies in the hope that they provide “better” data and a more ethical process that empowers children (Davis, 2009). At times, it is presented as a moral imperative while others caution that those involving child participants must consider what is realistic within their own research context (Davis, 2009:155).

Participatory research appears to refer to and incorporate a rather wide range of research practices. Indeed, some appear to claim inviting children as participants (see Fernandez, 2007) or that using “child-centred” methods such as drawings, games and photography (Clark, 2001) is participatory. More frequently, however, participatory research with children would imply that children have had some input on aspects of design or analysis, for example (e.g. Holland, Renold, Ross and Hillman, 2010). Some researchers train children in research methods so that they can carry out their own studies (Kellett, Forrest, Dent and Ward, 2004). At this end of the participatory spectrum, it is hoped that child researchers may improve on the access to certain (hard to reach) participants and certain (sensitive) topics (Kirby, 1999). For the child researchers, the experience has been said to be empowering, aiding their own development and future employment opportunities, for example (Sinclair and Franklin, 2000, Kirby, 1999 in Davis 2009).

The notion that participatory research is inherently and morally superior to other approaches is seductive if perhaps naïve. Countering the idea that participatory research *necessarily* produces better data, flattens power hierarchies or enhances

ethical integrity, Gallagher and Gallagher (2008) highlight that most of the so-called participatory research processes are usually still controlled by adult researchers; they also argue that the new and “innovative” approaches are simply extensions of school practices or classic ethnographic research methods so neither “better” nor “new”.

Holland and colleagues have also questioned issues of power, ethics and agency in participatory research practice with young people (2010). Drawing on their participatory research experience with young people in care, some of whom they involved in participatory research, they questioned the authenticity of voice and raised concerns around participants’ involvement in analysis. Participants’ preferred mode of engagement is often group discussions, but these can result in stronger voices drowning out those that are more quiet, so does not amount to equal involvement. Based on their experience with attempting to involve participants in analysis, Holland et al also highlight the issue of confidentiality that meant participants could not analyse across cases but only their own case. Further, had participants’ analytic accounts been accepted fully rather than as one aspect of many, the result would have been “sanitised” according to the authors (2010). Finally, they raise the issue of participation perhaps being more desired by researchers ticking a box than participants themselves, a point previously made by Birch and Miller in reference to feminist research (2002 in Holland et al, 2010). Hill’s study of the ways in which children would like to be involved in research supports this concern as it underscores the weak evidence base for such an argument (2006).

Similar to critique levelled at the UNCRC, the Childhood Studies perspective has been challenged because its notions of the child are specifically focused on issues more relevant to the Minority World, such as enlisting parents and governments to protect children and offering avenues for children and young people’s participation which may be limited (for example, Valentin and Meinhert, 2009). For example, paid work is not included in Childhood Studies’ proposed “child participation”. Instead, participation is constructed as something that takes place within schools and families and being heard by adult decision-makers in particular ways. Such norms arguably belong to a Minority rather than a Majority world as it can exclude many Minority world children and young people who work, do not live with their

biological parents, live on the street, or are applying for asylum or refugee status for example (Tisdall, 2012). Proposing only certain notions of appropriate participation for children and young people appears both limited and limiting.

Empirical evidence of pluralities of childhoods across Minority and Majority worlds and between different communities or groups of children supports the central concept of social constructionism in Childhood Studies theory by acknowledging the variation of childhood across space and time (James and James, 2004). It also supports the importance of structuralist and social causation arguments in that social factors determine the position of children in different societies. Studies have paid attention to the differences between children, and their experiences and understandings of their worlds and everyday lives as well as the different constraints put upon their agency in different parts of the world (James, 2010).

The increasing emphasis on the pluralities of childhoods has been challenged by Jens Qvortrup, however (2005, 2008). Essentially, his argument is not with the concept as such, but that the emphasis on it is premature because it obscures the commonalities of childhood such as the structural position of children that he believes is more important to underscore. His argument echoes a feminist debate in social sciences. For instance, it was necessary to highlight the common cause for women in the early feminist movement, to later diversify and recognise different womanhoods (Qvortrup, 2005). James suggests a resolution to this dilemma where the macro-structural commonalities of childhood are seen as the major determinants, but within which there is micro-diversity (James, 2010). Micro-diversity can be seen within work on agency, the subject of the next sub-section.

3.3.4 Conceptualising agency

According to Childhood Studies, children possess agency and are not just shaped by the world around them but actively shape it (Prout and James, 1990). Conceptually, agency can be understood as:

An individual's own capacities, competencies and activities through which they navigate the contexts and positions of their life worlds, fulfilling many

economic, social, and cultural expectations, while simultaneously charting individual/collective choices and possibilities for their daily and future lives. (Klocker, 2007, p 82)

Childhood Studies takes agency as a topic for investigation in order to understand children's social worlds and the world from a child's point of view. There are many examples of studies illustrating children's agency within the micro-context of their families (Lareau, 2003), living with terminal illness (Bluebond-Langner, 1978), deciding about their medical treatment (Alderson and Montgomery, 1996) and responding to poverty (Redmond, 2008).

Children have also been shown to be competent in managing relationships both with each other and adults (Alanen and Mayall, 2001), a central concern in Childhood Studies is that these capacities, competencies and activities of children to influence and shape their worlds are constrained by a subordinated position to adults (although wider structural issues, of course, affect adults as well as children). Imbalances in child/adult power and strategies to even these out are frequently referred to in research literature informed by Childhood Studies, particularly in methods literature (reviewed in Chapter 4). Defined as "non-adults" by adults, children occupy a different social position than adults on the basis of that position. Children's worlds, such as the family and school, operate on the basis of (hierarchical) relationships between children and adults. Childhood is structured *in relation to* adulthood, hence "child" is a relational concept (Aries, 1972, Alanen and Mayall, 2001).

Despite such recognition of relations and child agency, child-adult interactions have been less researched. As a central concern of this thesis, some of the empirical work on child resistance will be discussed here to demonstrate both the agency of children and how it may be constrained depending on both an overall child status; and across the world depending on different views of children per se; but also the agency of children of different ages and in different settings and circumstances.

Age and perceptions of competencies associated with it affects children's ability to exercise their agency. For instance, in a Welsh study with children aged 8 to 12 looked after by authorities, age was an important factor in the perceived right to

make decisions. Children said they thought they should be given more trust and freedom at the age they were but also argued against more freedom for younger children based on their ages, thereby maintaining the association between power/status and age in their accounts. This observation illustrates “the ongoing debate between children and parents about the importance of age as a marker of status, privilege and competence” (Kelley, Mayall and Hood, 1997, p 322).

Different settings prescribe different views of, and opportunities for, child agency depending on adults’ constructions of childhood in any given setting. Comparing the micro-settings of home and school, life at home is more encouraging of child agency and points of view in negotiations around adult-imposed rules than schools are (Mayall, 1994). Indeed, Thomas and O’Kane found that children experienced school as a more controlling setting than home with room for much less (or no) negotiation, although they also report that their participants create pockets of “free” time within the school day (1999). Their participants also reported differences between different (private) homes they stayed in. Many reported negotiations and “pleading” with adults to push back temporal and geographical boundaries, so they can come home and go to bed later and go further away with their friends.

I will now provide more detail of two empirical examples of studies demonstrating child agency, in rural Bolivia and urban Scotland, respectively, to discuss commonalities but also variations in child agency. I have chosen these two ethnographic studies to review in more detail as particularly interesting examples of child/adult interactional analysis going beyond child resistance per se, as that is also the aim in this thesis.

Sam Punch has published extensively from her ethnographic study of children in rural Bolivia (for example 2001ab, 2002, 2003), however, this summary will focus on her findings around child and adult relationships. Her participants live in the small Bolivian community of Churquiales, a disadvantaged and relatively isolated rural area, which lacks basic services such as electricity and drinking water. The fieldwork took place over three years and included participant observation, classroom task-based methods and interviews with all members of a sample of 18

households (2001a). Bolivian children in rural areas help out with household chores such as feeding animals and fetching water “without question or hesitation” (2001a:27). Expected to work, these children are also aware of their valuable contribution to their families and are encouraged, indeed expected, to be independent. Despite the pride they appear to take in their work, at times they would prefer to do other things and this is where little acts of resistance to subvert adults’ power over their time is relevant. Punch describes children’s accounts and her observations of numerous strategies of avoidance, coping and negotiation. Children escape tasks by pretending not to hear the request, taking longer to do another task than necessary, persuading a sibling to do the task, combining work with play, complaining and attempting to persuade parents that a sibling should do it instead. Strategies are not always effective but are facilitated by children’s opportunities for mobility and avoiding the surveillance of adults when outside. Parental responses to such acts of defiance or avoidance differ. Individual preferences and household needs can be balanced in different ways within different families. Some attempt to negotiate, others turn a blind eye or punish children depending on many different factors, some individual, such as strictness and moods, others structural.

Vicky Plows’ study of child/adult youth workers interactions in Scottish youth clubs (2012) show some similarities and differences to the child adult relationships in Punch’s work. In Plows’ study, children appear to have much more room to negotiate with adult youth workers relying on children’s voluntary attendance to justify their own work. Drawing on observations of challenging interactions between youth workers and young people, Plows shows youth workers and children engage in a negotiated process of sharing control. Her ethnographic study took place in a youth club involved within the grounds and building of a secondary school in a relatively disadvantaged Scottish community. Managed and staffed by a youth development group, children aged 11 to 14 attend voluntarily. Initiated because of concern from local shopkeepers about the disruptive behaviour of children in the area during their school lunch breaks, the club is attended by some of the “most challenging” children in the local area according to the youth workers.

This setting provided fertile ground for exploring children’s challenging behaviour

within a relational framework. Within the youth club setting, challenging behaviour belonging to children can be construed as agency, albeit a type of agency that makes youth workers feel uncomfortable. Youth work is a particular form of child-adult interaction that straddles two (at times perhaps incompatible) aims of empowering and constraining children. Responsible for both regulating the spaces, activities and development of the young and as facilitating the empowerment of children in participatory approaches, the role of a youth worker can be ambiguous (Plows, 2012). Given that within the youth club children decide whether they attend and when they attend and youth workers are dependent on this attendance but youth workers also control access to the space and equipment, the behavioural rules they need to abide by are considerably more flexible than in the school, for example, and the power balance is perhaps less asymmetrical than that of a teacher and pupil. Much of the social interaction in the youth club that Plows describes involves pushing the boundaries of others. For example, a regular feature of child-adult interaction is a youth worker's asking a child to abide by the rules and stop swearing, use the equipment properly, not to litter and so forth. The interactions that such requests spark involve the negotiation of power and control, as the children can either choose to accept and comply with the request or challenge it. If challenged, the youth worker can then, in turn, insist that the child changes their behaviour or retreat. Plows describes a continuum of the children and youth worker sometimes exerting, at other times relinquishing, control. Put simply, what a child does will influence what the youth worker does, which, in turn, will influence the actions of the child and so on in an interdependent pattern of actions. The social processes involved in negotiating challenging interactions in the context of child-adult relations show how they are framed by the power relations between the two social groups (of young people and adult youth workers). Moving beyond a description of adults constraining young people's power in much Childhood Studies research, Plows explores occasions when the boundaries between such dichotomies are blurred – “where adults and children disrupt stereotypes of what it means to be a child or an adult through ‘alternative ways of being’” (Hopkins and Pain 2007:292). She argues convincingly that it is too simplistic to conceptualise adults as inherently more powerful than children. Rather, the young people and youth workers negotiate a means to coexist by sharing control. The process of sharing control is dependent

upon their interdependence. Plows reports that it was as unusual for any child to repeatedly resist a youth worker's requests, as it was for a youth worker to continue to exert their control. Retreating, in the form of compliance was also a display of agency according to Plows. Here, she supports Punch's point (2001) that agency can be seen as much in compliance as in resistance.

These two studies exemplify differences in the constructions of childhood and the opportunities for child agency in Majority and Minority world settings. Children's power to subvert adult-imposed rules (as well as the much wider structural issues) are generally more constrained in the former. There are also differences in the contexts of the studies in that youth work aims to promote child agency while farm-work and the other work the Bolivian children engage in is essential for their families' survival. Both promote and assume independence albeit in different ways. Therefore, while child agency may be more constrained for Punch's participants than Plows', several similarities can be seen in both studies in demonstrating children's strategies for influencing, defending and constructing the social orders established and maintained by adults. While Plows' analysis of child-adult interaction is from a Minority World urban youth work context, similarities are evident from a study in rural Bolivia, thereby demonstrating the commonalities as well as the differences in childhoods across Minority and Majority Worlds.

Successful negotiation attempts appear to depend on an interaction of factors relating to the settings, the child and the adults. Within Childhood Studies, many examples of children and young people as active social actors currently exist. These studies are examples of a nuanced and contextual conceptualisation of childhood agency. In other studies, the end-point of it appears to be to counter the passive stereotype of children by showing that they are not only shaped by their social context but shape it. While an important point, it can become repetitive when agency is neither problematised nor nuanced, as suggested by Bluebond-Langner and Korbin:

... anthropologists have both asserted and clearly documented children's agency, singly and in groups, in a number of situations. What is less clear is the degree of agency, the impact of that agency, let alone the nature of that agency – points that could also be made about the agency of adults –

singly or in groups. Children, like adults, do not escape structural constraints. (Bluebond-Langner and Korbin 2007:242)

A focus on children's agency can discount contexts where such agency is constrained or simply not possible (White and Choudhury, 2010). A more helpful and nuanced way to consider child agency, suggested by Klocker, may be to discuss a continuum of agency, which varies depending on a number of factors, such as context and position of power (2007). She suggests that the idea of "thick" and "thin" agency can be helpful in understanding this continuum of children's agency and how different contexts may constrain it:

... 'thin' agency refers to decisions and everyday actions that are carried out within highly restrictive contexts, characterized by few viable alternatives. 'Thick' agency is having the latitude to act within a broad range of options. It is possible for a person's agency to be 'thickened' or 'thinned' over time and space, and across their various relationships. Structures, contexts, and relationships can act as 'thinners' or 'thickeners' of individual's agency, by constraining or expanding their range of viable choices. (2007: 85)

Klocker's work in Tanzania shows that child agency can be very constrained in a culture which does not allow for resistance but where children find ways of subverting adults' power over them in small but important ways (2007).

Social realities are invariably complex and serve to constrain child *and* adult agency to some extent but this is not acknowledged in much Childhood Studies research, with methods literature referring to ways in which children's agency is constrained but seldom the ways in which adult researchers agency can be constrained, for example.

If viewed as a more complex concept, child agency could be seen as depending on aspects that may constrain it, such as class, race, disability and the physical environment (valentine, 2011). Pointing to the example of feminism, valentine argues the emphasis on differences within different groups of women (while all subordinated) is a useful example for Childhood Studies, which should emphasise differences within different groups of children (2011).

valentine's point is important, if not new. In the very first book published on the Sociology of Childhood, Corsaro made the same point when he wrote "*children are, by their very participation in society, constrained by the existing social structure and by societal reproduction*" (2011:18). Although children are active agents, he explains they are constrained by the social, economic, cultural and political contexts of that society, just like adults. Children who live in one context may have a lot in common but at the same time individual children may also have very different constraints within their own sub-contexts (Corsaro, 2011).

Overall, Childhood Studies research has attended more to examples of positive and rational child agency than occasions when children resist what may be perceived to be in their best interests (valentine, 2011). There is a danger that child agency becomes romanticized. Plows' point about challenging behaviour is relevant here, in that those most privileged may be those whose behaviour is interpreted as agency rather than undesirable. Equally, because of the increased constraints on child agency in disadvantaged circumstances and the Majority World, there is a risk that less privileged children come to be seen as inherently having less agency, rather than their agency being "thinned" because of social structure. When interpreting agency this must be kept in mind so that children from disadvantaged circumstances are not recognised as lesser agents than those from different backgrounds.

As a concept, power is almost exclusively represented as a negative repressive adult force and as something that can be handed over or equalized in Childhood Studies. However, Gallagher argues that power is a social phenomenon that, (paraphrasing Foucault) is not always an evil (2008). Rather than a static entity, power is fluid and contextual and not always possible to know (Christensen and Prout, 2002).

3.4 Conclusion

This chapter has discussed Childhood Studies, the approach that this study is informed by. Emerging as a counter-paradigm to the previous developmentally-informed paradigm that positioned children as passive human "becomings" rather than human beings and privileged adult to child voices, it has led to an explosion of

research illustrating children's agency, competencies and voices. More recently, the underpinning principles of Childhood Studies have been problematised (Tisdall and Punch, 2012, Tisdall, 2012, Gallacher and Gallagher, 2012). Critics point out that Childhood Studies, in borrowing concepts and methodologies from other disciplines in relatively naive ways, may have neglected to turn its critical lens on the ambivalences in its key "mantras". For instance, the constraints on child agency have not always been recognized despite the first book devoted to the perspective recognising the importance of it (Corsaro, 2011) and in its assumptions in the focus on child voice. Fissures are thus emerging in what has long been a remarkably unified approach, remarkable in light of its interdisciplinary nature. Such fissures are likely to nuance rather than weaken Childhood Studies and are a key element to its future development.

Evidently, the distinctions between adult and child, agency, power and the lack thereof, are not as clear-cut as suggested in some of the writing in the first phase of Childhood Studies. The second phase of Childhood Studies is grappling with many of its central tenets to develop ones with more nuance. Childhood Studies is therefore at a critical juncture that holds the possibility of a more nuanced and reflective approach to researching children's experiences. Reflexivity about the ways in which social science researchers' work contributes to the construction of childhood and how children should be treated is encouraged. This means adherence and attention to ethical practices for researchers exploring the views and experiences of children. The next chapter will provide a reflexive account of the process and methods of this study and the successes and challenges in my attempts to adhere to principles of Childhood Studies. To date, the child in most SHS literature has been constructed as passive and vulnerable in the lack of child voices, the adult proxy respondents and the assumed passivity on behalf of children. Much SHS research appears more reminiscent of studies with child participants before, than those following, the rise of Childhood Studies. In subscribing to many of the underpinning principles of Childhood Studies, this study contrasts with earlier research on children and SHS. At the core of the design and analysis of this study is an understanding of children as social active agents who are as active in the social construction of their worlds and shaping of family life and society as a whole as adults are.

In discussing the application of Childhood Studies to my study in the next chapter, some of the issues discussed in this one will resurface there and in the remainder of the thesis, especially matters of child agency, voice, and how children assemble and give meaning to their own and others actions. While recognising the value of the body of work demonstrating child agency, Adrian James has questioned what the continued proliferation of such studies adds (2010). I will return to his question in Chapter 8 in light of the findings of this thesis.

Chapter 4: Research Design, Methods and Methodology

4.1 Introduction

This chapter details the research design, methods and methodology of the study, much of which was informed by Childhood Studies as reviewed in Chapter 3. It begins with a brief overview of the research design, aims and settings and proceeds with a reflexive and approximately chronological account of the research process. I detail the adjustments made to the research questions and design after the first few instances of data gathering, and the process of negotiating access to, and consent of, the participants. The chapter then proceeds to discuss the data collection, my role as a researcher and approach to data collection, analysis and dissemination. Ethical practice was an ongoing consideration in this study (Sime, 2008) and will be detailed throughout this chapter.

4.2. Overview of study and epistemology

This study aims to develop an understanding of child participants' perspectives and roles in negotiating smoking in the home and car, one that moves on from the passive way in which children have been positioned in much previous SHS research (reviewed in Chapter 2). My epistemological position is interpretive and constructionist; I am interested in participants' interpretations of their worlds from their point of view. In this vein, the ways in which they construct and assign meaning to their own actions and others will be my focus rather than uncovering "the truth" or what "really" happens in families where parents smoke. In gathering and analysing accounts, I believe these still draw on and reflect 'reality' to an extent but the nature of their beliefs is not necessarily accessible to uncover completely. Instead, participants' accounts can highlight social norms and other issues pertinent to design interventions more sensitive than those designed without such an understanding.

Given the unpredictable, complex and reflexive behaviour of people, the interpretive approach holds that research should aim to improve our understanding rather than provide cause and effect explanations of human behaviour but providing understandings which can to some extent be generalised ‘in moderatum’ for participants in similar circumstances (or theoretically) (Williams, 2000). The importance of the meaning and understanding participants ascribe to smoking in the home takes as its point of departure that most people (children and adults), most of the time, are rational and sensible in their choices if we can understand the constraints they are under, what their priorities are and what they are trying to achieve.

The aims and approach in addressing children’s perspectives are closely aligned to the ontological, epistemological and methodological elements of Childhood Studies. Childhood Studies posit that although children, as a (heterogenous) group, frequently occupy a more subordinate position in society than adults (Morrow, 2005), their perspectives should be sought in a way that attends to the inherent power asymmetry between child participants and the adult researcher. Gathering children’s perspectives neither need, nor should, be mediated by proxy adults as has occurred in some previous SHS research. Indeed, because children are more often excluded from SHS research than adults they are, arguably, due an “epistemic advantage” (Holland et al’s expression in relation to research with less heard groups such as children, 2010:371).

This study is designed to contribute to, and in a small way unite, two separate research fields. One is that of children’s perspectives and agency within Childhood Studies paradigm(s), which, to date, have not explored their views and experiences of smoking in the home or SHS, and the other is the emerging field of accounts of everyday interactions relating to smoking in the home, which, to date, have focused on the experiences of adults. Alongside this, the study was designed to explore and compare the contexts in which smoking in the home takes place between two communities of very contrasting socioeconomic profile, as socioeconomic factors are known to influence smoking practices (see Chapter 2). It is hoped that information of this kind will not only improve our understanding to help inform future

interventions into smoking in the home and car. The study aims have been articulated in the following research questions:

1. What are 10- to 15-year-olds' accounts of their understandings and experiences of SHS in the home and car?
2. What is the nature and extent of their involvement in decisions around smoking restrictions in the home and car according to them?
3. How do accounts of understandings, experiences and involvement contrast among children and young people living in communities of contrasting socioeconomic profile?
4. What are the implications for health promotion interventions aimed at reducing children's exposure to SHS in the home and car?

I recruited participants from two Edinburgh areas of contrasting socioeconomic profiles to enable the comparison of accounts from participants living in different circumstances, as an inverse relationship between SHS exposure and socioeconomic status has been demonstrated (Whitlock et al, 1998). Furthermore, the social context of smoking is an important factor in the shared smoking behaviours of a community (Dedobbeleer et al, 2004, Frohlich et al 2000, Poland et al, 2009).

The significant contrasts in socioeconomic status and smoking patterns between the two communities selected are summarised in Table 1. This table uses figures from 2004 that formed the basis of the selection of communities for a larger comparative community study by Martin and colleagues, which evaluated the impact of the smokefree law (2008) as well as the selection of communities in this study. Data from 2004 are used as more recent community statistics from 2010 by the Scottish Public Health Observatory only include one of the areas concerned and does not provide smoking prevalence figures for it. These figures therefore apply to the areas two years prior to the implementation of the smokefree law and three and five years prior to my field work. It is possible that regeneration activity in the disadvantaged

area (such as new housing observed when I conducted the fieldwork) and the smokefree law may have altered the socioeconomic profiles and smoking prevalence statistics somewhat since then.

Community and socioeconomic characteristic	Edinburgh	Social Grade*		Adult smoking rate	Smoking rate in pregnancy
		A-B	E		
Disadvantaged	Urban	7.1%	37.1%	50.7%	37.7%
Advantaged	Sub-urban	48.1%	11.2%	18.8%	16.5%

Table 1: Community profiles

*Grade E : on state benefits, unemployed or in lowest grade workers

Grade A-B: higher and intermediate managerial/administrative/professional occupations

Source: Community Profiles, NHS Health Scotland, 2004.

The socioeconomically disadvantaged area (from here on referred to as the disadvantaged area) is one of the most disadvantaged in Edinburgh and consists of mainly council housing and has a high unemployment rate and smoking prevalence. Subject to extensive economic and social regeneration over a 20-year period, the area is located on the edge of Edinburgh and has retail outlets, community facilities and bars, and is the location for local authority and health board activity. On my field visits, I was struck by the high visibility of smoking by people on the streets and outside pubs, shops, and the community centre, an observation which Martin et al's study observations support (2008). The advantaged area was similar to a small suburban village, located a few miles from Edinburgh city centre. There are two pubs, a few cafes and small restaurants, some of which had gardens or access to outdoor spaces which smokers would be able to use. In contrast to the disadvantaged area, I observed very little smoking on the streets and very little evidence of it in the form of cigarette butts on my recruitment and data collection visits there.

Fieldwork began with some "sensitising" work to check the appropriateness of my approach and terms with two boys who acted as advisors at this early stage. I then collected data from eight participants participating in a focus group, two paired interviews and an individual interview in October-December 2007. After maternity leave, I resumed recruitment and conducted individual/paired interviews and focus groups with another 30 children and young people between February and November

2009. Participants were recruited from a youth club in the disadvantaged area, Girl Guides in both areas, and a church group and the Scouts in the advantaged area. Identifying children whose parents or other close family members smoked in the advantaged area presented a challenge, mainly as a result of a low community smoking prevalence. Recruiting boys posed another challenge. Nine of eleven boys were recruited from the youth club in the disadvantaged area; the other two boys were the only boys in a very large Scouts group who identified that their family members smoked. Despite repeated attempts to gain permission to recruit from a boxing and football club in the disadvantaged area, my phone calls and emails were mostly unanswered and initial vague assurances of permission to visit remained unconfirmed. The final sample reflects these recruitment issues in that I recruited mostly from the disadvantaged area and mostly girls: 27 children from the disadvantaged and 11 from the advantaged area, 27 girls and 11 boys.

While I carefully planned the research design and process, I adapted aspects of my research strategy that would not work as intended. Early analysis has, to some extent, shaped data collection. The different stages of the research process have, to an extent, overlapped and informed each other in a “bricoleur” (Levi-Strauss, 1966) approach where the researcher adapts and reacts to what happens in the field rather than setting out with a completely predetermined and set idea of what the data collection will look like. In the remainder of this chapter I will attempt to describe the research process in an approximately chronological order, beginning with the preparation for field work and selection of methods, continuing with recruitment, data collection and analysis and ending with dissemination of the findings.

4.3 Preparing and planning for the fieldwork

Prior to this study, my experience in researching children’s experiences was limited to a study of children’s perceptions and beliefs of cancer where I was part of a team. We used the Draw-and-Write technique with children aged 8 to 11 in five Scottish schools in areas of contrasting socioeconomic profiles (Knighting, Rowa-Dewar, Malcolm, Kearney and Gibson, 2011). Participants were asked to draw, and write on the drawings if they wished, cancer, what caused cancer and what might prevent it.

While I enjoyed the experience and found the technique of draw-and-write interesting, I had some concerns about the way in which child participants were accessed and the method of analysis. Children were asked their assent, rather than consent and parental consent was privileged. Despite the distribution of colourful and attractive information leaflets, Flesch tested (a test for reading comprehension) for the age group, many children appeared not to have heard of the study before our arrival. Participants appeared very concerned about giving correct answers and interacted with us in the way they might with a teacher, by putting their hands up to speak, for instance, probably attributable to the classroom setting and our lack of involvement with the children beforehand. Despite attempting to interact with the participants in an informal manner, introducing ourselves with our first names and dressing informally, the teacher remained in the room and we were introduced as coming from 'the university' and our study appeared to be perceived as a regular school activity which they were expected to participate in. This experience left me with an interest in pursuing more research with children, but in a manner more sensitive to the various ethical and analytic issues raised here.

The selection of study design was, to some extent, bound by the initial outline of the research study devised by my supervisors, Professor Amanda Amos and Professor Sarah Cunningham-Burley, in their application for CSO studentship funding. While the outline stipulated the use of a qualitative approach to explore the views and experiences of children and young people residing in two communities of contrasting socioeconomic profiles, it left the precise methods for the student to develop. To aid this decision process, I read extensively about research with children and soon came across debates about what informed consent with children entails, the draw-backs of research in school settings and critique of "creative methods" especially draw-and-write (Backett-Milburn and McKie, 1999). After my first year of study I had also become aware of other ontological, epistemological and methodological debates within research with children and recognised Childhood Studies as *the* approach to use in research with children (despite an emerging critique of the approach, which has since gained momentum and is reviewed in Chapter 3). I was also aware of the dearth of work within the field of SHS from an interpretivist or Childhood Studies perspective. An interpretivist approach within the social sciences differs from a

positivist approach as the latter tests causal relationships and the former stresses the importance of what a social process means from the perspective of those within it. There is relatively little research of family interactive processes by interpretivist researchers compared to positivist approaches-primarily because the privacy of family life and the family home can make many methods used within interpretivist research such as ethnography appear intrusive. I will discuss the choice of appropriate methods further later in this chapter. The lack of previous research on children's experiences of SHS in the home and car combined with my own inexperience of researching with children made me decide to engage in some "sensitising" work prior to the study proper.

4.3.1. Sensitising work

A participatory approach is often advocated in Childhood Studies as it is thought to improve the process and outcome of research with children, but, as Chapter 3 discussed, such success is not inherent in the approach itself. My intention with involving two children in the preparation phase was more pragmatic and informed by an approach I had previously used in my role as a cancer care researcher where we consulted advisory groups with people affected by cancer who advised us on acceptability, feasibility and other issues we may encounter in the research process with other people affected by cancer. I wished to check the appropriateness of the terms and methods I was intending to use and also gain some experience in talking to children about SHS. With these aims in mind, I approached a former colleague who smokes and her two sons, aged 10 and 12, to ask if they could advise me, which they agreed to do.

I talked to the boys informally for about 30 minutes' each in their home, individually at their request. I assured them that they did not have to answer my questions, that we could stop talking any time of their choosing and that I would not tell their mother either what they said, or indeed if they chose to not talk about the study with me. We discussed their understandings of SHS, the sources of that information, the terms they used, their opinions of the draft consent and information forms and their preferences for individual, paired interviews or focus groups. I avoided personal

questions about what they thought about their mother's smoking and their role in negotiating smoking restrictions as the boys were not participants but advisors. While the boys used some more personal information to illustrate their points I did not note that information. The boys confirmed that the information and consent forms were pitched at the right level, and particularly approved of the use of colour in the information design, commenting the consent forms were good as they were "not boring" and may alleviate some of the concerns children unused to participating in research may have.

As a result of these discussions, I reduced the information sheet in length and was made aware of the need to verbally explain the study as if potential participants had not received the information sheets as "some may not read it anyway". The younger boy said he would prefer to be interviewed individually because "it's easier to talk about family on your own than with people listening". In contrast, the 12-year-old boy said he would prefer to be interviewed with friends because it would be "a laugh". This confirmed my idea of offering a choice of methods to suit each participant if possible. I showed the boys a number of pictures of smoking in cars, outside and inside and a line drawing of a family where the parents smoked, used previously in tobacco education with Joy Lane (2007), which they preferred. As a small token thank you I gave the boys boxes of their favourite chocolates.

Talking to the boys dispelled my concern that SHS might not be an issue of concern for children or that they may have nothing to say or not want to talk to me about it. The way in which the boys made sure the door was properly shut and kept watching their mother carefully through the conservatory glass door told me interviews in the home might make future participants concerned about confidentiality. While the boys appeared comfortable talking about smoking in the home, they expressed a concern about other participants being identified and singled out as "the one whose parents smoke" that made me realise the importance of a sensitive recruitment approach.

4.3.2 Selecting methods

When selecting methods my aim was to engage children in a respectful, ethical and enjoyable way conducive to generating data on parent and child interactions around smoking restrictions, what those restrictions were and understandings of SHS. Inspired by Sam Punch's work with Bolivian children (2001, 2002), I wished to combine a method that would be more fun and perhaps engage children more as well as more conventional semi-structured interviews and focus groups. Given the scarcity of research on smoking in the home with child participants, whether smoking in the home would be a "sensitive" issue for participants was unclear. Of course, all topics have the potential to be sensitive so no research method is appropriate or inappropriate in itself (Farquar and Das, 1999). Previous research with mothers who smoke (Robinson and Kirkcaldy, 2008, Coxhead and Rhodes, 2006) suggests there are moral implications in asking about parents smoking practices. In a study investigating child accidents, Baruch reflected that when interviewing parents about their interactions with health professionals concerning their children's congenital heart disease, the implicit question behind the interview appeared to be how parents had neglected their moral responsibility as parents (1981). Children, too, may feel uncomfortable, or disloyal, discussing parental smoking practices which could affect their health. Indeed, Backett-Milburn and McKie state that being and keeping healthy can be "as much moral issues for children as it is for adults" (1999:395). In Backett's and Alexander's study (1991) with young children, participants appeared resistant to identify any of their parents' behaviours as "unhealthy" and the lack of mention of smoking was noteworthy. However, in a large focus group study on 11- to 20-year-olds' perceptions of smoking, the issue of SHS exposure was frequently and spontaneously raised in reference to personal experience of their parents smoking in the home (Allbutt et al, 1995). The 16 to 20-year-olds seldom mentioned SHS and 15- to 16-year-olds failed to mention SHS in groups that contained smokers and non-smokers, so the sensitivity (or interest) in this issue in a group context may be dependent on the age and smoking status of participants.

In most research studies, the researcher has more power than participants over the

research process, the selection of research questions, methods, analysis and dissemination of results. Further, because of the inequalities of status and age existing between adults and children, a power asymmetry can potentially be exacerbated by the researcher and the researched roles (Morrow, 2005, Mauthner, 1997, Christensen and Prout, 2002). With the aim of making the process as ethical, fruitful, comfortable and enjoyable as possible, I made a number of decisions around venues for recruitment and data collection, methods and my own role as a researcher, some of which were aided by the participation of the two boys at the sensitising stage, to be further adjusted after the first few participants. Some researchers have attempted to bridge potential power inequalities by increasing participant involvement in other facets of the research process such as research topics for example, but this would have amounted to tokenism since the research questions were already set prior to my own involvement (see Chapter 3 for further critique of the assumption that participatory research is inherently better).

Every setting brings a history with it and children may draw on previous encounters with adults in the settings and make assumptions based on such experience (Dockrell, Lindsay and Lewis, 2000). Adults are generally expected to guide, care and be responsible for children, expectations that are based on legal and cultural frameworks. Specific settings may also carry particularly strong expectations of child and adult relations. For example, school-based research can be imbued with the conventions of teacher-child relationships, as suggested by previous literature (Dockrell et al, 2000) and my own experience of researching children's perceptions of cancer (Knighting et al, 2011). I wished to avoid the pupil/teacher connotations the adult/child interaction might involve, particularly because of the expert/novice interaction where they might think the object of the activity was to give the "correct" answers rather than their own experiences. Children might also feel obliged to take part in the study or to be in peer groups they had not chosen, raise their hands, wait their turn to speak and speak directly to the facilitator rather than each other in the way they might be expected to in other school activities. In this way, differences in power can be exacerbated in the school setting where adult authority is particularly pervasive with implications for issues such as informed consent (Porcellato, 1999, Woods et al, 2005).

Youth club settings provide an alternative to schools where I imagined participants might have experience of less formal and hierarchical relationships with adult youth workers there. While youth clubs and groups also involve adult/child power differentials I hoped they would be less stark and that non-involvement in the study would be less noticeable and that involvement would be more on the participants' terms (Greene and Hill, 2005; Highet, 2003).

A second consideration was the need to provide participants with some control over the research process, particularly whether they wanted to participate or not. Children are frequently the last to be asked (Green and Hill, 2005), so I planned to ask potential participants as early on as possible in the process. Further, I also planned to consult the first participants about preferences within the process, and to allow participants a (albeit limited) choice of ways to be involved. To decide which methods suit the purposes of the study best I wanted to try them out in practice and ask children to evaluate them. However, as I could not try out an infinite number of methods, I based my initial choice of methods on the literature outlined below and decided on individual and paired interviews, focus groups, and tasks and visual stimulus methods to stimulate talk. The following sections describe these in turn.

Paired interviews

Individual interviews are often a preferred method in social research, considered particularly appropriate when asking participants to share details on their lives and families (Morrow and Richards, 1996). However, the experience of "being questioned" by adults can be intimidating to children. For instance, in an interview study with 85 10- to 11-year-olds in Ireland on smoking, Rugkasa et al (2001) reported that contradictions and monosyllabic answers were frequent during the 20-minute interview making analysis difficult (2001:134). Berry Mayall advocates addressing the asymmetrical power balance between the researcher and the child (noted by many other researchers including Morrow and Richards, 1996, Mauthner, 1997 and Christensen and James, 2000) by using friendship pairs in interviews with children (Mayall, 2000). Creating a supportive social context, paired interviews let children follow each other's leads, responding and initiating discussion with their

friend and thereby moving out of the asymmetrical adult interviewer/child respondent relationship (Mayall, 2000). Paired interviews can be described as a hybrid between individual interviews and focus groups. Proponents of this method suggest it has the benefits of the individual interview of depth of data and access to private accounts while also possessing the benefits of the focus group in diluting power relationships, facilitating natural conversation and providing greater insights into group norms (Amos et al, 2006; Highet, 2003), something I was also interested in exploring. Paired interviews thus offer more of a social context than individual interviews by offering opportunities for interaction between participants, but less power differential between the researcher and the researched. Further, the paired interview is often the participants' preferred option (as reported by Highet, 2003; Michell and Amos, 1997).

Despite these perceived advantages, paired friendship interviews are relatively rare in research and often conducted with children younger than my participants as a means to increase the confidence of participants (Mayall, 2000; Mauthner, 1997; Mulvihill et al, 2000). The small number of smoking studies with children and young people of 12-19 years of age resulted in rich, interactional data on participants' perceptions of addiction and smoking cessation (Amos et al, 2006), cannabis and cigarettes (Highet, 2003) and peer groups and smoking (Michell, 1997). Cautioning against using this method for some types of peer relationships with strict hierarchies, Highet suggests that a sensitive selection of friendship pairs which necessitates some prior meetings with the participants and knowledge of the context in which they operate, is crucial to avoid this potential issue (2003). Paired interviews thus have the benefit over individual interviews of outnumbering the interviewer and providing data on participant interaction, an advantage shared with focus groups.

Focus groups

Varying in composition and duration, focus groups are generally made up of a group of people encouraged to discuss a certain issue by a facilitator who asks them open-ended questions with the aim of eliciting participants' perspectives (Barbour and Kitzinger, 1999, Hennessy and Heary, 2004). The interaction encouraged in focus

groups can enable participants to generate ideas in reaction to one another and is said to strengthen their voices in the research process as they have more control over the topics discussed (Hennessy and Heary, 2004). Such interaction allows researchers to examine different perspectives and the ways that these operate and influence others within a social situation (Kitzinger and Barbour, 1999). Claimed to “approximate meaning making within naturally occurring social interaction” (Bergin et al, 2003:15), focus groups are the preferred method to explore group norms because of the way they examine social context as something which can alter and shape beliefs (Kitzinger and Barbour, 1999, Heary and Hennessy, 2002). Despite the interaction making focus groups unique, it is neither evident nor analysed in much focus groups research as pointed out by several authors (Darbyshire, MacDougall and Schiller, 2005, Green and Thorogood, 2004, Kitzinger, 1994).

Whether this interaction is advantageous or not in research with children has been debated. Children have been found to be more comfortable in the company of their peers rather than on their own with an adult researcher (Hill, 2006). In removing the emphasis on the relationship between adult and child (Hennessy and Heary, 2004), paired interviews and focus groups give participants greater control of the direction of the conversation (Barbour and Kitzinger, 1999; Kitzinger, 1994; Wilkinson, 1998, Darbyshire et al, 2005; Davis, 2001; Hoppe et al, 1995; Morgan, Gibbs, Maxwell and Britten, 2002; Punch, 2002). Importantly, unlike an interview, participating in a focus group does not mean pressure to answer every question posed by the facilitator. The support of peers in a focus group situation may also be one that facilitates greater openness (Mauthner, 1997; Basch, 1987).

The group interaction that focus groups foster also constitutes one of its limitations, however. All children may not want to share their personal experiences with a group of others and some participants may be silenced if only the views of the more confident group members are heard (Kitzinger, 1994). Further, the desire to fit in with peers can lead to “group think” as participants strive to reach a consensus rather than face peer rejection by voicing a different opinion (Bergin et al, 2003). Some suggest that focus groups should be composed of small friendship groups to avoid this scenario. In this way, it is argued, participants will trust and know one another

well enough to be less reticent to voice an alternative opinion (Morrow, 1999).

However, friendship groups carry other potential risks such as breaches of confidentiality (Michell, 1999). Further, when carrying out focus groups when the participants know each other, it may be more difficult for participants to voice certain opinions as they may be concerned other participants will repeat what they said afterwards. In Lynn Michell's work with 11- and 12 year-old girls on peer pecking order and how these structures influence health behaviours, marked differences were apparent between the accounts generated in the "public" context of a focus group and the "private" individual interview (Michell, 1999). No personal accounts of bullying emerged in the focus groups and some participants remained quiet, while individual interviews revealed tales of bullying and underlying factors such as difficult home circumstances. On the other hand, if some accounts are not suppressed, the public disclosure of private information can potentially compromise ongoing social relationships children may have in school or in their community (Michell, 1999; Greene and Hill, 2005). The potential of "over-disclosure" makes Greene and Hill argue that focus groups can exploit children by encouraging them to disclose views they may have wished to keep private from peers (2005).

Both focus groups and paired interviews rely on children answering questions to some extent, providing them with little time or control over the format of their answers or perspectives that cannot be accessed through verbal communication. Researchers have therefore developed more "child-friendly" methods, designed to work with the different capacities and preferences of children and young people, giving them more control of their answers.

Visual stimulus methods

Some children are more reserved in a group setting; others may feel an individual interview is more like an "interrogation" or "investigation" (McWilliam et al, 2009:70). In some studies with children, visual methods and methods such as drawings and Draw-and-Write considered more "child-friendly" and as harnessing children's expertise, have replaced or supplemented traditional talk-based methods

(Pridmore and Bendelow, 1995, Thomson, 2008). When drawings are used as a stand-alone method, to later be interpreted by researchers, Backett-Milburn and McKie point out that it is based on the flawed notion that children draw what is in their minds when they are more likely to depict common representations of concepts, especially with abstract concepts such as health (1999). Rather than using drawings in this way, they propose using the technique as a springboard for discussion, advice more recent draw-and-write studies have heeded (Mulvihill et al, 2000; Piko and Bak, 2006). This “recent turn to the visual” has been identified in research with children and young people (Spyrou, 2012:153) and includes drawings as well as photography, photo-elicitation, scrap books and maps (Thomson, 2008). These methods require children to talk about pictures or maps they took or ones presented to them by the researcher and hold a number of advantages over talk-based methods according to proponents. Proposed to prompt rich and different accounts, visual methods may also be a more fruitful and enjoyable way of engaging children who find it challenging to express themselves verbally or in written formats (Thompson, 2008, Leitch, 2008). Further, in co-creating data rather than being the sources of them, it can address the power asymmetry between researcher and participant (Leitch, 2008:37). In Leitch’s study of children’s rights in Northern Ireland, she reports that participants produced drawings and collages that appeared to promote narratives of what may otherwise have been “unsayable” regarding children’s rights in Northern Ireland (2008:48) and based on a review of four studies she proposes that producing drawings are “intrinsically motivating” in a way that more traditional methods may not be (2008:48).

Given that my research is about a health practice in certain places, it appeared to lend itself to visual representation. Despite this, visual methods appear not to have been used in previous smoking in the home research and drawings and maps are usually a method with participants under 12 years of age (Mulvihill et al, 2000; Piko and Bak, 2006). I considered a number of different visual research techniques including asking children to take photographs of their homes or taking walks with children around their homes so they could show me where smoking was permitted. However, I had concerns about the ways in which this might compromise participants and their families’ anonymity when disseminating findings. One of the other options

considered was to ask children to either draw and/or indicate, on a map of their local community, and indicate where smoking was permitted and where they saw people smoking. Given the purpose of the study is to explore participant perspectives of smoking in their homes and cars, rather than their communities, I thought of ways in which participants could produce a “map” of their home instead. Inspired by the floor plans produced by architects and estate agents that represent all the rooms of a home, I thought of a simplified version indicating all rooms in the home where participants could tell me about smoking restrictions. As I was also considering using focus groups and paired interviews, I thought this would be a good way of acquiring individual data from each participant about their smoking restrictions that they could tell me about while constructing the floor plans.

To stimulate discussion about smoking restrictions and the nature of SHS, I also planned to use a drawn image of a family watching TV in a sitting room while the parents are smoking (see Figure 1), previously used in health education by Joy Lane (2007). Lane found the picture to be an effective way to prompt discussion about understandings of SHS and really engage children, and the boys in my sensitizing work liked it. I thought about using this picture to prompt discussion about ways in which a room could be made less smoky and thought of one of the participants who volunteered to lead this discussion and writing down the suggestions of other participants on a flip chart. Such discussion could serve to highlight both participants’ understandings and also their suggestions for how to reduce smoking in the home and car.



Figure 1: Family stimulus picture (Lane, 2007)

Combining methods

Combining talk with visual methods is often promoted as “child-friendly” (Punch, 2002a) and as providing a holistic picture of the issue at hand by triangulating data outputs (Punch, 2002). Triangulation can also imply that there is one fixed and true reality to uncover by combining multiple data sources (Richardson, 1994:522), an assumption more akin to the positivist rather than interpretive perspective. Instead of seeing a triangle of all points meeting at a central fixed point, Richardson suggests that the crystal through which we see reality depends on the facet or angle of the crystal (1994:523). Less contested advantages of using multiple research techniques are that they provide an answer to a number of quandaries in research with children: how to engage children and young people more effectively; how to make the research process more enjoyable; and how to lessen the inherent adult-child power relationship (Darbyshire et al, 2005; O’Kane, 2000; Punch, 2002a). For example, Punch prefers mixing “traditional” methods used with adults, such as interviews and focus groups, which treat children as competent social actors in combination with

“task-based” visual methods to account for children’s different position in society and making the power differential less pronounced. Darbyshire et al (2005) applied different methods for different purposes as follows: focus groups were applied to explore group norms; and mapping to explore perceived barriers and enablers in the environments and photographs for the children to depict the physical activities they engaged in. Concrete differences in the data provided in the focus groups, maps and photographs are demonstrated in the results, for example, trampolines were frequently depicted in the photographs but never mentioned or drawn in the focus groups and the maps.

Using several methods allows children to make choices, argues Darbyshire et al, but provide no examples of children participating in less than all methods (2005).

Arguably, providing children and young people with a choice gives them greater control to make the process more suitable to the participant (Highet, 2003; Punch, 2002a; Edwards and Alldred, 1999; Mayall, 2000). With a few exceptions (Highet, 2003; Edwards and Alldred, 1999) this approach is rarely used, probably because the application of a range of methods complicates the analytic process and makes awareness of the advantages and disadvantages of each technique for the data produced essential (Punch, 2002a).

The study design is detailed in section 4.5.1. The chapter now turns to the recruitment process.

4.4 Recruiting participants

4.4.1. Negotiating access to children

The process of gaining access to, and the informed consent of, child participants frequently involves obtaining many layers of permission. The first step in this process was to apply for a “disclosure” certificate from the government organisation Disclosure Scotland, who check the criminal history information of those seeking to work regularly with children or vulnerable adults. As I intended to carry out individual interviews with children, I applied for Enhanced Disclosure. An enhanced

disclosure means that even “non-conviction” information known to the police and considered relevant would be disclosed if present on any criminal records. On being granted Enhanced Disclosure, I applied for ethical approval for my study at the University of Edinburgh, a process which involves outlining the purposes, methodology and research procedures of the study, justifying the need for children’s involvement and attest that they would come to no physical or psychological harm through taking part in the research (see Appendix 1 for the ethical approval documentation). Only once these two permissions had been granted began the process of seeking permission to recruit from the two communities, a process which involved seeking further permissions from adults before talking to potential participants about the study.

Despite the potential to recruit a more balanced sample in terms of age and sex from schools, I decided to attempt to recruit from child and youth groups in the communities for reasons discussed later in this chapter. I contacted all ten child and youth groups in the areas, visited seven and recruited from five. Participants were recruited from a youth club and Girl Guides in the disadvantaged area and a church group, Girl Guides and the Scouts in the advantaged area, but prior to recruitment I had to gain consent from adult group leaders to visit the groups and recruit children. Despite the possible benefits that recruiting from community groups entailed, it also entailed a greater number of gatekeepers with associated negotiations and subsequent adjustments to their different requirements and concerns.

I observed differences in my discussions with gatekeepers in the advantaged and disadvantaged areas. The two youth group leaders in the disadvantaged area had experience of providing access to researchers and, once convinced the study was worthwhile, made quick decisions to grant initial access to the children. They agreed with my decision to have opt-out rather than opt-in parental consent both ethically and pragmatically. They agreed that the children attending their club were of an age to make their own decisions about taking part, as long as they were asked in a sensitive way, even though they also acknowledged the need for parents to be informed and given the option to opt their children out. In their experience, opt-in consent would also result in very few participants as parents seldom returned forms.

In the advantaged area, however, the four gatekeepers representing a local church group, the Scouts, Girl Guides and Army Cadets were apprehensive about what the research process would entail both in terms of time and child protection, particularly the opt-out rather than opt-in parental consent and about data collection occurring without the presence of an adult “chaperone” referring to the child protection protocols of the organisations they represented. Negotiations were time-consuming and the recruitment period typically spanned several months and, on two occasions, more than seven months from initial contact to recruitment. I became aware of an inherent tension, and at times contradiction, that exists between academic and Childhood Studies thought and child-protection protocols. This tension is clear in the way that children are broadly viewed as having the same rights to participation, confidentiality and informed consent as adults in the former and as particularly vulnerable and in need of protection in the latter. Gatekeepers’ concern with parental as opposed to child consent resulted in some children’s informed consent being compromised. The “ethical symmetry” in the ethically equal way researchers treat child and adult participants proposed by Childhood Studies (Christensen and Prout, 2002:482) means that the key ethical principle of autonomy is as important to uphold for children as it is for adults.

However, there is a heightened concern over children’s safety where children have increasingly become a “protected species” (Scott, Jackson and Backett-Milburn, 1998), in need of protection from strange adults. Legally and socially, children are viewed as dependents and are often seen as more vulnerable and less able to decline participation than adult research participants. The opportunity to contact potential child participants directly, as competent social actors is limited. Instead, access to children and young people usually requires “gatekeepers” who have the power to allow or deny access to potential participants. Once access has been granted and the participants have consented, gatekeepers’ involvement can also have implications, both for the research process and outcome, as I found in this study. Operating in a socio-cultural context less concerned with principles of ethical symmetry and more with issues of child protection, I had to adapt. I sensed the power relationship between the Scout Master, Girl Guide leader and, in particular, the Army Cadet Officer in command and the children to be significantly more pronounced (and

probably not unlike the school hierarchy I had attempted to avoid) than the youth workers and the children from the disadvantaged area. While I attempted not to reproduce these in my interactions with potential participants by introducing myself by my first name, sitting amongst small groups of children, chatting informally and dressing in jeans, my adult identity was still clear and some of the local adult-child culture may also have had an impact on the way children behaved with me.

Despite the importance of the researcher and gatekeeper interaction, this field relationship has only been paid scant attention in methodological literature. A few notable exceptions have raised important questions of “the politics of access” in terms of how gatekeepers view male researchers in child research with an element of suspicion (Horton, 2001) and their power to redesign research questions (Barker and Weller, 2003). Yet there has been almost no discussion of how the researcher-gatekeeper negotiations impact on the researcher’s meetings with children once access has been granted (except Heath, Charles, Crow and Wile, 2007). Referring to child protection regulations, they insisted on the presence of two additional adults with enhanced disclosure during the interviews. This resulted in interviews with three participants in the Church group being chaperoned by other adults with enhanced disclosure, a situation which appeared to impact negatively on the data as discussed in detail later.

After this experience, I explained to the other gatekeepers how it compromised confidentiality, a concern they were sympathetic to. In the Girl Guides, the gatekeeper and I reached a compromise by me keeping the door open so she could see but not hear us and when the gatekeeper in the Scouts heard about this, he was happy to let me talk to the two participants recruited from his group in a room on our own.

In the advantaged area, there was also an element of resistance from all gatekeepers approached, not observed in the disadvantaged area, to the very idea that some of the children in their care might have parents or close family members who smoked.

4.4.2. Gaining informed consent

When recruiting participants I wanted to ensure that participants were informed about the nature and purpose of the study before consenting and that they were under no pressure to participate from me or anyone else, according to the principle of informed consent. Seeking child consent has been subject to much debate within Childhood Studies relating to their perceived competence or incompetence to consent, the protection of children, and the relative rights of parents and children. While research with children used to be based on consent from parents or legal carers and children, standard practice is now to ask both children and parents for consent. Rather than the need for child consent, the debate has moved on to question the need for *parental* consent for research, which some argue is condescending to older children who are capable of making up their own minds about participating (Masson, 2000, Coyne, 2010). Berry Mayall (1994) has linked this debate to the subordinate position children continue to occupy in society:

It is indeed a marker of the control exercised over children's lives, knowledge and rights in the UK that children's own consent to research is not considered adequate. (Mayall, 1994:133)

Unless researchers can demonstrate that gaining parental consent would involve sharing confidential information which the children may not wish to share (for example, drug taking or gang membership), most ethics committees will still not grant permission for studies with children without parental consent, however. A compromise was reached between upholding the principle of child competence and rights to decide and formal ethical requirements by asking for opt-in consent from children and opt-out consent for parents, retaining a clear emphasis on child consent.

This multi-layered process of consent is also usually one where the child's own consent is the last sought, and France (2004:183) highlights researchers need to be mindful when the often protracted process of obtaining consent through multiple gatekeepers can overshadow the central concern of *informed* consent from potential children and young people themselves. Accordingly, I sought potential participants' consent as early as possible in the process, prior to parents but by necessity after

youth group leaders, treating children as competent actors capable of making their own decisions (Christensen and James 2000b). Great care was taken to design accessible information leaflets in colour with a photograph of myself, which in simple language explained the key points of the research study (according to the Flesch testing) (France, 2004). Information sheets detailed the purposes of the study, what their participation would involve, that they did not have to participate and my contact details should they wish to ask any questions. Parents were sent information sheets containing an opt-out slip they could return in an SAE should they not wish their child to participate (see appendix), which no parents did.

Six participants were not present during recruitment visits and were instead recruited by gatekeepers who distributed information sheets on my behalf. However, (at least) three gatekeepers took initiatives to provide parents with information and consent forms *prior to* the children being approached and verbal consent sought in addition to the opt-out parental consent. It emerged that at least two of these participants were instructed by their parents to participate in an interview about smoking without having read the information sheet, as detailed later.

4.4.3. Final sample

The final sample comprised 38 10- to 15-year-olds. There were 27 girls and 11 boys; 27 from the disadvantaged community and 11 from the advantaged community. Pragmatic constraints and ethical concerns during recruitment, discussed in chapter 4, led to the end of data collection after interviewing 38 participants. While I believe this sample was sufficient, it may have benefited the study to have a sample with a more balanced gender, class and age ratio. However, given SHS is more prevalent in disadvantaged areas and lack of evidence of any gender difference in exposure to, or views of, SHS, the skew towards those from a disadvantaged background and girls, may not necessarily have been an issue.

All participants were white, reflecting the (predominant) ethnic composition of the areas. Four participants from the advantaged area did not have smoking parents but were recruited as they had other close family members who smoked, such as older

siblings and an uncle who spent a lot of time in their home. Six children from the disadvantaged area said that they smoked themselves. Smoking status is indicated in the participant table as there were some subtle differences in their accounts compared to those who did not report they smoked, as discussed in chapters 4,5 and 6. The names are pseudonyms, selected from lists of the most popular Scottish names in the years the participants were born. Participants will be identified by a pseudonym (chosen from the most popular Scottish baby names in the years participants were born, avoiding real participant names), area (D indicating disadvantaged, A indicating advantaged), whether they are a smoker (s for smoker) and their age, for example, Thomas D12s indicates Name AreaAgeSmoker. Communities will be referred to as advantaged and disadvantaged.

Pseudonym and identifier	Area and group recruited from	Age	Method	Family member who smokes	Smoking status	Mother/father occupation
RyanD14	Youth club, disadvantaged area.	14	FG & II	Father, uncles.	N/s	Manual/ Unemployed
JamesD14	Youth club, disadvantaged area.	14	FG&II	Parents	N/s	Manual/ Unemployed
ThomasD15s	Youth club, disadvantaged area.	15	FG &II	Parents	S	Manual/ Manual
RebeccaD14	Youth club, disadvantaged area.	14	PI & II	Parents, grandmother, friends.	N/s	Unemployed/ Unemployed
JennaD15s	Youth club, disadvantaged area.	15	PI & II	Parents, aunt, friends.	S	Manual/ Unemployed

LaurenA13	Church group, advantaged area.	13	PI	Father.	N/s	Professional/ Unemployed
JessicaA12	Church group, advantaged area.	12	PI	Brother.	N/s	Managerial/ Managerial
ChloeA11	Church group, Guides, advantaged area.	11/ 12 *	II and FG	Father	N/s	Managerial/ Managerial
JackA11	Scouts, advantaged area.	11	II & PI	Father	N/s	Professional/ Managerial
MichaelA12	Scouts, advantaged area	12	PI	Father	N/s	Managerial/ Professional
CatherineA13	Guides, advantaged area.	13	FG	Father	N/s	Unemployed/ Professional
MelissaA12	Guides, advantaged area.	12	FG	Siblings	N/s	Unemployed/ Managerial
CatrionaA13	Guides, advantaged area.	13	FG	Father, grandmother.	N/s	Manual/ Professional
AnnaA12	Guides, advantaged area.	12	FG	Stepmother, uncle.	N/s	Managerial/ Professional
EmmaA12	Guides, advantaged area.	12	FG	Uncles	N/s	Professional/ Professional
JenniferA14	Guides, advantaged area.	14	II	Mother	N/s	Managerial/ Professional
AmyD12	Youth club, disadvantaged area.	12	FG	Parents	N/s	Unemployed/ Manual
VictoriaD12	Youth club, disadvantaged area.	12	FG	Parents	N/s	Unemployed/ Unemployed

LauraD12	Youth club, disadvantaged area.	12	FG	Mother	N/s	Unemployed/?
MeghanD11	Youth club, disadvantaged area.	11	FG	Parents, grandparents.	N/s	Manual/ Manual
NicoleD12	Youth club, disadvantaged area.	12	FG	Stepfather.	N/s	Unemployed/ Unemployed
IslaD12	Youth club, disadvantaged area.	12	FG	Mother, grandparents, siblings.	N/s	Unemployed/ Manual
JuliaD11	Youth club, disadvantaged area.	11	FG	Stepfather.	N/s	Unemployed/ Unemployed
AbigailD12	Youth club, disadvantaged area.	12	FG	'Everyone'	N/s	Manual/ Unemployed
AmberD10	Youth club, disadvantaged area.	10	FG	Parents, grandparents, uncles.	N/s	Manual/ Manual
TaylorD14	Guides, disadvantaged area.	14	II	Mother	N/s	Manual/ ?
LeahD10	Guides, disadvantaged area.	10	FG	Parents	N/s	Unemployed/ Manual
LindsayD11	Guides, disadvantaged area.	11	FG	Parents	N/s	Unemployed/ manual
AlexaD10	Guides, disadvantaged area.	10	FG	Grandparents, uncles and aunts.	N/s	Manual/ Manual
RobbieD10	Youth club, disadvantaged area.	10	PI	'Everyone': Parents, siblings, grandparents.	N/s	Unemployed/ Manual
FraserD11	Youth club, disadvantaged area.	11	PI	Grandparents	N/s	Unemployed/ ?
RachelD13S	Youth club, disadvantaged area.	13	FG	Parents.	S?	Unemployed/ Unemployed

DanielleD15	Youth club, disadvantaged area.	15	FG	Parents.	N/s	Unemployed/Manual
ErinD13	Youth club, disadvantaged area.	13	FG	'Everyone': Parents, siblings, aunts, uncles.	N/s	Unemployed/Unemployed
LewisD13S	Youth club, disadvantaged area.	13	FG	Parents	S	Manual/Manual
SeanD14S	Youth club, disadvantaged area.	14	FG	Parents	N/s	Manual/Unemployed
MarkD13S	Youth club, disadvantaged area.	13	FG	Parents	S	Unemployed/Unemployed
MattD14	Youth club, disadvantaged area.	14	FG	Grandmother	N/s	Manual/?

Table 2: Participants

II: Individual Interview

PI: Paired interview

FG: Focus group

S: smoker

N/s: non-smoker

? No contact with father

* ChloeA11 was aged 11 while in the church group, and aged 12 in the FG.

Determining socioeconomic status

I recruited participants from two Edinburgh communities with contrasting socioeconomic profiles because smoking prevalence and smoking restrictions in homes and cars differ significantly according to socioeconomic status. Households of widely contrasting socioeconomic status can still exist within any given area, however, so it seemed prudent to supplement their postcode with another measure of socioeconomic status.

Given that children are in school rather than in an occupation, have little or no income and have not yet entered higher education, measures generally used in adult populations are inappropriate. Instead, proxy data on parental occupation is often

used, and such data were gathered in this study (see table 2). Nevertheless, Currie and colleagues have found that asking children and young people about their parents' occupation can result in missing data in the region of 20-45% (2008). This may be because adolescents are uncertain of what their parents' occupation is, or may not want to reveal it (as non-response is more common in lower SES groups).

Low response rates prompted Currie and colleagues to develop a Family Affluence Scale (FAS) (Currie, Molcho, Boyce, Holstein, Torsheim, and Richter, 2008). Currie et al based their selection of relevant items indicating deprivation or affluence on Carstairs and Morris' (1991) and Townsend's (1987) classic work on material deprivation. Using the notion of material conditions in the family to determine SES, the first FAS measures measured telephone and car ownership and single bedroom occupancy as indicators of relative affluence or deprivation. In the last decade, the FAS has been adapted in a number of ways to reflect current economic conditions and allow cross-country comparisons. Telephone ownership is not as strongly linked to SES internationally as it was in Scotland in the early 1990s so has been removed and measures about the number of family holidays and family computers have been added to more recent versions of the scale.

I noted participants' postcode and parental occupation using items from the 2001/2002 Family Affluence Scale II (car, bedroom occupancy, family holidays plus computer ownership) (Currie et al, 2008) after interviewing them. Despite Currie's et al's concerns, asking participants about parental occupation was not an issue in this study and all appeared confident in telling me whether their parents worked and what they did. It is possible this difference reflects the difficulty of avoiding a direct question from a researcher compared to the relative ease of not completing one item on a questionnaire, as in previous work by Currie and colleagues. However, I did not detect any sense of discomfort in answering the question from participants in either area. There was some discomfort in reading and writing, however, related to literacy skills so I quickly changed from giving them the questionnaire to complete, to asking the questions and recording the answers myself. Consequently, one of the adjustments was to avoid tasks dependent on literacy skills.

All participants in the advantaged area had at least one parent in a professional or higher managerial occupation, including lawyers, doctors and bank managers, and all participants in the disadvantaged area had parents who were unemployed or in manual occupations, such as cleaners and plasterers. Postcodes indicated all participants lived in the specified areas. While FAS scores are higher in the affluent area overall, differences are not particularly indicative of SES differences. For instance, one participant in the disadvantaged area and two participants in the advantaged area share a FAS score of 6, mainly because Rebecca D14's family owned more than 2 computers and Jessica A12 and Chloe A11's family owned one computer. With Rebecca D14's parents both unemployed and residing in a highly disadvantaged area compared to Jessica A12 and Chloe A11's father being a professional and residing in a highly advantaged area, postcode and parental occupation appear to be better indicators of SES. Overall, the number of computers owned appears a highly misleading measure of SES as all families owned at least one, with three participants from the advantaged area and two participants from the disadvantaged area owning more than two computers. Accordingly, the lifespan of certain FAS items may be limited due to rapid changes in technology that influence price and consumption patterns, as also acknowledged by Currie et al (2008).

Differences in socioeconomic status are evident in the floor plans that participants constructed. All participants in the disadvantaged area lived in similar houses with three bedrooms, often sharing bedrooms in contrast to participants in the advantaged area who all had in excess of 3 bedrooms and several other rooms used as living rooms, second living rooms, studies, and dining rooms. Indeed, many of the participants from the advantaged area had some difficulty remembering all the rooms in their houses. Consequently, the area participants lived in provided an adequate indicator of socioeconomic status as supported by parental occupation and floor plan information.

Six participants (three from each area) were recruited as they had close family members who smoked – siblings, grandparents, aunts and uncles – rather than parents who smoked. This pragmatic solution to a recruitment issue in the advantaged area served to highlight more of the public discourses related to smoking

as these two focus groups included many more disagreements about the rights of smokers versus non-smokers. Six participants from the disadvantaged area smoked themselves; three of them were in the same focus groups with a boy who did not smoke: the other three participated in focus groups and a paired interview with children who did not smoke. Accounts from participants whose parents did not smoke or who smoked themselves differed from those who did not, in ways that will be detailed in the data chapters.

4.5. Data collection

This section details how the data were collected. In some ways, it is also an account of power, mine as a researcher, individual participants' power and the power balances between participants. As detailed previously, before entering the field my concerns around power imbalances centred on those between participants and I. However, it became increasingly evident that other power imbalances also affected the data, specifically those between the gatekeepers and I, and between participants. Although I have directed the research process more than anyone else within it, the contextual and fluid nature of power (Gallagher, 2008) meant it has not always resided with me as the researcher but shared in various positive, but also at times challenging and uncomfortable, ways between gatekeepers, participants and I.

4.5.1 The study

In qualitative studies, "research design should be a reflexive process operating through every stage of a project" (Hammersley and Atkinson, 1995:24). Gathering and analysing data, and refocusing and modifying research questions, often occurs simultaneously, each process influencing the others. Initial research designs may need to be altered during the study in response to new developments in a flexible manner (Grady and Wallston, 1988). My study conformed to the iterative research design process of many other qualitative studies as this section will demonstrate.

The first focus group and paired interviews I conducted were with three boys and two girls from the disadvantaged area and three girls from the advantaged area

between October and December 2007. I will discuss the situations that arose in these first instances of data gathering separately as I made decisions based on them that had consequences for the study design in the remainder of the study. The boys chose to be interviewed in a focus group and the two girls in the disadvantaged area chose to be interviewed together. These first five participants were also interviewed individually the following week. Two of the girls in the advantaged area chose a paired rather than an individual interview and the remaining girl, who had not been present the first week, was interviewed individually by necessity rather than choice. Given the timing and setting of the data collection in the advantaged area – a busy church in the two months leading up to Christmas – serial interviews were not possible and all data collection took place in one session.

I chose focus groups to investigate participant accounts of their views and experiences of smoking in the home and car because they provide opportunities to ask open-ended questions around this topic and to learn from the issues raised and deemed important by the participants. Being particularly interested in the types of behaviour perceived as acceptable in relation to smoking restrictions, I was also motivated to use focus groups as I anticipated that participants would be more likely to give responses which would be accepted and endorsed by their peer groups whilst in their company and in this way illustrate social norms. Differences in gender perspectives of health issues and how boys and girls can inhibit each other in a group context has led many researchers to select single-sex groups within the 11 to 16 age groups (Michell, 1997; Amos et al, 2006), and I followed suit. Given that other studies reviewed here highlighted the distinct differences in the accounts produced in focus groups from those produced in individual interviews, I planned to conduct single-sex focus groups and paired interviews to examine group norms and then met participants a second time and interview them individually. Meeting participants several times might allow access to more private and as well as more “public” or acceptable accounts of experiences. During the focus groups I planned to use the stimulus family picture and a flip-chart to allow participants to take over proceedings a little, while during the individual interviews I planned to ask participants to draw a floor plan of their home and describe their smoking restrictions. To keep the chronological thread of the chapter, the process of negotiating access to participants

will be discussed before the process and outcome of this first group and pairs.

The individual interview was these first participants' least preferred method. They stated a preference for focus groups and paired interviews because ideas could be discussed and responded to by others in the group: "*Easier to talk when you're in a group. People agree with you and ...*" (Thomas D15s) and there was reduced pressure to answer quickly: "*It's different, you've more ideas to come up with, people talk and then I think and stuff*" (Rebecca D14). Preferences for being interviewed in a groups or pair depended on the other participants being friends, otherwise they might feel "*shy*" (Thomas D15s) and awkward while friends would not tease you or pass judgement:

James D14: it's [focus group] better with your friends

NRD: And why is that?

James D14: You're not getting any bother 'cause they know about everything anyway.

However, individual interviews may have improved participant privacy and control, as suggested by the following instances. First, the only participant who asked not to be recorded was one of three participants I interviewed individually, possibly suggesting that the privacy of the interview gave her more control to ask for it to be set up according to her own preferences. Second, another participant made no mention of his asthma in the focus group that he participated in, until he was interviewed individually afterwards, possibly because the former was domineered by another participant.

The family picture proved popular because it aided understanding and gave participants ideas they may otherwise not have thought about:

Like you understand it more when it's in front of you. (Jenna D15s)

'Cause, like it shows you more what's happening. So if you had [just] asked us I'd probably wouldn't know.' (Lauren A13)

The pictures were good, easy to talk about, especially the family picture there was more of it to talk about.' (Chloe A11)

'Cause you could like see what was wrong with the living room...' (Thomas D15s)

Opinions on the flip chart task were not as positive and were divided along lines of participants who thought they were good at writing and spelling and those who did not. While the two participants who had volunteered to write the results of the brainstorming task on the flip chart had enjoyed the task, those who had watched in the disadvantaged area disliked the method. As a result of these views, the flip-chart task was not used after the first pair and focus group in the disadvantaged area.

Jenna D15s: I didn't like that 'cause I'm not a good speller and not good at writing.

NRD: So you think other young people who aren't good spellers may feel really uncomfortable with that?

Jenna D15s: Probably, 'cause I would have [had you asked me].

NRD: What about the flip-chart when [P1a] wrote ... if I had asked you to write what would you have thought?

James D14: Mmm ... I'd rather not.

NRD: Why is that?

James D14: I don't like writing.

NRD: Yeah, he volunteered but had I asked someone who didn't like it as much ... it would be better if I didn't?

James D14: Yeah.

All participants enjoyed drawing a floor plan of their house to aid the individual discussion of smoking restrictions. This task also served to clearly identify area differences, both in the extent of smoking restrictions and the space available and

provide individual data of smoking restrictions more challenging to note down in a group situation. At the end of the evaluation of methods, participants were asked to suggest potential improvements but all said they had enjoyed taking part and “*liked the way you did it*” (Chloe A11) and that it was “*good this time*” (James D14).

For children, Pia Christensen suggests confidentiality “*has a particular resonance ... whose relationships and friendships are performed through the engagement with telling and keeping secrets, revealing secrets to other children or ‘telling adults’*” (2006:171). Participant confidentiality appeared to conflict with child protection procedures in many of the organisations the children were recruited from, with the Scouts, the church group, Guides and Cadets all having protocols stating that an adult is not permitted to be alone with a child. Children speaking for themselves by themselves thus became an unexpected tension in negotiating access to children with gatekeepers, despite the focus groups and paired interviews meaning I was not seldom alone with a child but with several. The gatekeeper in the Church group in the advantaged area insisted on the presence of another (fully disclosed) adult volunteer “observer” during interviews, referring to their child protection policy. In the paired interview, two adult males observed the interview and one adult female observed the individual interview. This tipped the power balance in favour of adults and appeared to affect the quality of the data gathered as will be described later in this section.

Consequently, the paired interview was a particularly awkward experience for both the participants and I, associated with the presence of the “chaperones”. One of the chaperones was an attractive young man whose presence appeared to make the girls self-conscious and they blushed and giggled throughout the interview. On my part as an interviewer, it also added an uncomfortable sense of surveillance to what was one of my first data collection experiences in the study. Participants appeared particularly perturbed when asked any questions relating to challenging parental authority such as asking parents to stop smoking (this question was posed after Lauren A13 stated her Dad smoked and she thought SHS was horrible):

NRD: So have you told him that you don't like him smoking ... ever?

Lauren A13: Nooo [laughter and looking at Jessica A12].

NRD: [laughter] No? Why not?

Jessica A12: Ehm ... 'cause it's what he wants to do. He always does it 'cause he wants to so I don't think I have the right to say.

NRD: Ok, and is that because you want to be polite or ... you know how you also said that when other people smoke you would never tell them not to – is that because you don't want to be rude or because it's not such a big deal, or ... ?

[silence]

Lauren A13: People have a right to smoke...

Jessica A12: ...if they want to...

NRD: People have a right to smoke if they want to.

Lauren A13: I feel embarrassed to say you know not to smoke...

As is evident from the second extract, I lapsed into asking both a leading question and combined two questions into one in my rush to distract the participants and perhaps myself from the awkwardness of the experience. After this experience, I explained the importance of privacy to the gatekeeper and she agreed to let me be accompanied by one female chaperone well known to the participant during the next individual interview. However, despite carefully preparing this chaperone prior to the interview on the purpose and realities of research and asking her to remain in the background, she did not quite oblige as described in my field notes.

Despite me setting up the chairs so that me and [Chloe A11] were sitting next to one another with a table in front of us and [chaperone's] chair about a meter away, she immediately pulled it up very close between us and put her feet on [Chloe A11's] office swivel chair's feet, looking intently at us throughout the interview apart from when interrupted by others entering and exiting the office room we were in. She regularly butted in and laughed at jokes but [Chloe A11] and I managed to ignore her quite well.

On this occasion, I was determined not to let the presence of the chaperone affect my own role as an interviewer and the rapport with the participants. Chloe A11 and I

worked together to subvert the power of the chaperone by pulling our chairs closer, facing each other and not including her in our conversation.

Several issues were discovered during these first instances of data gathering that were adapted in future fieldwork, including adjustments to practical aspects of recruitment, briefing of gatekeepers and methods of data collection relying on participants' literacy.

The focus group and paired interviews were more popular amongst participants and appeared to elicit richer data. Whereas I had to probe and encourage responses in individual interviews, the participants appeared to be stimulated by one another to respond comprehensively in a group or paired situation. Children appeared encouraged to give their opinion when hearing others do so, as echoed by other researchers (Hill, Laybourn and Borland, 1996), with the exception of one participant who was more talkative in the individual interview than the focus group. He was relatively quiet in both, however, and may have been more talkative in the interview because of necessity rather than privacy. Unlike Hill et al (1996), I did not find that interviews worked better for shy participants but instead support Mayall's point that having one or two friends present can be supportive and enabling for those participants (2000). My role in the focus group and paired interview in the disadvantaged area was about facilitating bursts of focus group discussion rather than leading the conversation like in the individual interviews, which at times felt rather laboured. The interviews conducted in the advantaged area contain many more monosyllabic answers. While this can be attributed to age, gender and area differences, the specific circumstances of those interviews with other adult chaperones is likely to be the main culprit in stifling my rapport with the participants. Several participants in the disadvantaged area were not confident about their spelling, so the flip-chart brainstorming method was abandoned in subsequent fieldwork. Visual stimulus materials such as the family picture and the floor plans worked very well and were by far the most popular approach. It served to maintain participants' attention and interest more than the periods of straight questioning.

Other pragmatic adaptations resulted from these first pairs and focus group, such as

the importance of allowing sufficient time for recruitment in the advantaged area because of the lower prevalence of smoking and careful briefing of gatekeepers to arrange a setting more conducive to data collection than one with chaperones. Similarly, I realised that offering a choice of methods may not always be practically possible because of the low numbers of potential participants in the advantaged area. When initially asked which methods they preferred to take part in, no participant opted for an individual interview and the individual follow-on interviews did not add much to the initial paired or group discussion but instead felt repetitive and were very brief.

Aspects of using traditional focus group and interview methods with children differed from my previous experience of using them with adults, including the length and types of responses. Unlike adults' contributions to focus groups and interviews, the participants' contributions were typically short. In paired interviews and focus groups, the participants discussed matters with each other more and were prompted by each other, so these appeared to be better formats for future fieldwork.

The insights gained led to a greater emphasis on paired/ group and visual methods in subsequent fieldwork. My increased experiential, rather than theoretical, understanding of conducting research with children and young people also prepared me for potential challenges around negotiating access to children and young people through gatekeepers and in the current child protection climate leading to insights and alterations in the study focus and design, in addition to minor "tweaks" in procedures. After trying a combination of a focus group, then individual interviews with each focus group participant with the first 5 participants, I noticed that the data provided in focus groups appeared as personal as those obtained from individual interviews and the individual interview did not provide much new data. Given this realisation and the preferences expressed by participants for focus groups and paired interviews, the follow-up interviews appeared redundant and the remainder of the participants only participated in a focus group or paired/individual interview. Despite some adjustments to methods, the data from these first few participants were very similar to those of the remainder.

Recruitment and ethics

Ethically, the fieldwork is guided by the British Sociological Association's *Statement of Ethical Practice* (BSA, 2002) and Alderson's seminal child-centred approach described in "Listening to Children: Children, ethics and social research" (1995). Alderson begins by listing ten important issues for research with children that urge the researcher to consider: the purpose of the researcher; the costs and benefits of research with children; privacy and confidentiality; selection; inclusion and exclusion; funding; reviewing the research aims and methods; provision of information for children and parents/carers; consent; dissemination; and the impact on the children themselves (Alderson, 1995).

With most participants, I spent time during my first recruitment visits trying to get to know them a little better and develop rapport. We talked about how long they had attended the youth club or group, what they preferred doing there and I joined in with some of the activities. At the start (and end) of the focus groups and interviews I would also always informally chat with participants about their activities that session. I would then briefly reiterate information about the study and research process, using the information leaflet as a guide. Informed consent implies that "the individual who is to submit to research should be given full opportunity to exercise judgment in order to determine what will be done to his or her mind and body" (Kimmel, 1988: 28) but this became problematic when gatekeepers recruited on my behalf. They recruited six of the participants and I first met them when collecting the data. Participants recruited by gatekeepers were not always well-informed as exemplified by the following conversation with Michael A12.

NRD: ... did you have a chance to read the information sheet?

Michael A12: Nah, my mum read it though.

NRD: All right, but can I tell you quickly a bit about the study? And then you can decide if you want to be part of it still, if that's OK? [telling Michael A12 about the study and digital recorder] So what did your parents tell you about the study?

Michael A12: Well, my mum didn't really tell me she just asked me to do something so I just do it [laughter].

This small exchange illustrates the ways in which consent was not always informed until just before the research encounter due to gatekeepers preferring to recruit and then informing parents rather than children. While this illustrates that the power to consent was at times in the hands of gatekeepers who informed parents instead of children and parents who did not inform children, Michael A12 appeared to happily disengage from that part of the process before he engaged in the interview. During the (paired) interview, he appeared a little less comfortable than many other participants to talk about his father's smoking restrictions and their negotiations around them so it is possible that he might not have participated had he been fully informed prior to arrival.

After verbally informing participants about the study, I explained I would not discuss what they had said with others, including parents and gatekeepers. On some occasions, this guarantee had to be reiterated to gatekeepers when some expressed an interest in what participants had or would say during the interview, as described in my field notes.

Unprompted, [gatekeeper] also shared some personal details about Catriona A13's home-life saying her father had left and returned to the home several times and that 'it would be interesting to find out what was going on there'. So that she was clear on the confidentiality issue I told her it was unlikely it would come up but if it did I would not be able to tell her anything of what was discussed in the group, which she accepted. Such hints are always slightly awkward to respond to, as I don't want to misinterpret them or make people feel uncomfortable with the suggestion that they don't take confidentiality seriously. I was especially careful not to damage my relationship with [gatekeeper] in particular given our history of lengthy negotiations so was tempted to ignore her comment but at the same time I think it's important to clarify confidentiality issues to ward off later questions to me or even the other focus group participants.

However, I also explained to participants that I could not guarantee complete

confidentiality to participants given the obligation of researchers to alert appropriate professionals should a child reveal they were at risk (Mahon, Glendinning, Clarke and Craig, 1996:151). Detailing the limits of the confidentiality I could offer, I explained that if they disclosed that they were being seriously hurt by someone or they were hurting someone else I would discuss it with them first but also with someone in authority (such as the gatekeeper in the first instance). I assured them that their name and other identifying features of what they said would be anonymised but that their words might be quoted in reports and presentations. I asked them not to share what other participants said afterwards. The purpose of the digital recorder was explained to be so that I could remember exactly what they said but that only I would listen to the recordings. I gave them a choice to use the digital recorder or not, offering to take notes instead if they preferred. One participant, interviewed individually, asked me to take notes.

Rather than treating consent as a one-off event, I also began each focus group or interview by again stressing the voluntary nature of their participation, providing participants with a final say over whether or not they wanted to participate (Morrow and Richards, 1996). Further ensuring that consent was kept a “live” issue during the data collection process, I refrained from insisting that all participants answer all questions and paid close attention to any signs of unease. The open-ended nature of the questions posed to participants was intended to let the participants take them in other directions should they wish, guided by the principle that all participants choose the extent to which they wanted to share details about their lives. To stimulate discussion and illustrate questions, participants were shown a line drawing of adults smoking in the presence of children in a home environment and asked to draw a floor plan of their homes and indicate smoking restrictions on it. I began all interviews and focus groups with the first two questions and ended with the floor plans but the timing of the other questions were guided by participant responses.

- Say I had never smelt or seen cigarette smoke before or been near anyone who smoked. What is it like?

- Tell me about this picture (showing family picture and prompt if necessary:

what is happening in it?)

- How could you make this room less smoky? What about a car?
- Where have you heard about that?
- Who smokes in your home/car? Do people you live with do any of those things? Do they talk to you about why they e.g. go outside, open a window etc?
- Have you ever asked people who smoke not to smoke? Not to smoke near you?
- *Ask participants to draw a floor plan, indicating home smoking restrictions.* Where do people you live with or who come and visit smoke?
- *Point to restricted areas.* Do they sometimes smoke there? Why/why not? What would that depend on?

To alleviate participant concerns about the drawing skills required, I drew a very simple floor plan of my two-bedroom house. Demonstrating a floor plan was more directive than I had planned but I reasoned it was more important that participants were reassured that drawing skill did not present an obstacle to engaging in this task.

At the end of the focus group and interviews, I noted down data to help me determine their socioeconomic status, thanked the participants and later sent a £10 shop or mobile phone top-up voucher as specified by them. Considered common practice in much research with adults, thank you gifts to children are nevertheless contested depending on whether authors consider it an incentive or bribe or just “fair recompense” (Kirby, 1999, Mahon et al, 1996 and Alderson and Morrow, 2004). Part of treating children with ethical symmetry (Christensen and Prout, 2002) is that children’s and adults’ time and efforts are of equal value. Children have economic lives too. Further, when discussing my research with gatekeepers in the youth club, they recommended giving participants a small token thank you because of the

precedent set by previous research in the club. However, the vouchers were not mentioned until potential participants had expressed an interest in taking part. While I asked gatekeepers to do the same, one gatekeeper in the disadvantaged area mentioned it to two participants she recruited.

Those expressing an interest in participating in the study were, if at all possible, given a choice of participating in a focus group, paired or individual interview. While all preferred to be interviewed in a group or a pair, three participants were nonetheless interviewed individually because they were absent at the time their peers were interviewed. Consequently, there were three individual interviews, eight participants participated in four paired interviews and the remaining 27 participants participated in eight small focus groups (see Table 3). Paired interviews and focus groups were composed of participants from the same area and of the same sex and approximate age.

Method	Participants	Area	Sex	Age
Focus group 1	1, 2s, 3	Disadvantaged	Boys	14-15
Focus group 2	8i, 11, 12	Advantaged	Girls	11-12
Focus group 3	13, 14, 15	Advantaged	Girls	11-12
Focus group 4	17, 18, 19	Disadvantaged	Girls	11-12
Focus group 5	23, 24, 25	Disadvantaged	Girls	11-12
Focus group 6	27, 28, 29	Disadvantaged	Girls	11-13
Focus group 7	32s, 33, 34	Disadvantaged	Girls	13-15
Focus group 8	35s, 36s, 37s, 38	Disadvantaged	Boys	13-14
Paired interview 1	4s, 5	Disadvantaged	Girls	14
Paired interview 2	6, 7	Advantaged	Girls	11, 13
Paired interview 3	9, 10	Advantaged	Boys	12, 13
Paired interview 4	30, 31	Disadvantaged	Boys	10, 11
Individual interview 1	P1*	Disadvantaged	Boy	14
Individual interview 2	P2*	Disadvantaged	Boy	15
Individual interview 3	P3*	Disadvantaged	Boy	15
Individual interview 4	P4*	Disadvantaged	Girl	14
Individual interview 5	P5*	Disadvantaged	Girl	14
Individual interview 6	P8	Advantaged	Girl	10
Individual interview 7	P16	Advantaged	Girl	15
Individual interview 8	P26	Disadvantaged	Girl	14

*Pilot participants 1-5 were also interviewed individually briefly post focus group and paired interview (P8 did not want to be recorded).

8i/P8 participated aged 10 recruited in the church group, then in a focus group recruited in a Girl Guides group. By the time I realised she was the same girl I had interviewed a year previously (her appearance was very different; longer dyed hair, taller and wearing makeup) she was already in the room ready to be part of a FG so I let her take part again.

Table 3: Method of participation

Following Highet's advice (2003), I also attempted to group and pair friends together. However, three participants had no friends participating in the research and chose to take part in focus groups instead of individual interviews. This affected the interaction in that the person who was not friends with the others were quiet (although not disengaged) sometimes as a direct consequence of being teased by the others. Such instances will be described in detail in the data chapters as they had direct consequences for the data generated. They illustrate that power asymmetry between participants was, at times, as, or perhaps even more, important than the

power asymmetry between participants and I. Children are not a social group exempt from power differences ascribed to others and differences in class, age, linguistic skill and popularity shape dynamics (Christensen and James, 2000).

The focus groups and interviews in this study lasted between 25 and 45 minutes (with the five follow-up individual initial interviews lasting a maximum of 15 minutes each). When I initially used silences or verbal probes to encourage the participants to expand on their statements in the way I had in previous studies with adult participants, some would instead stop talking and look uncomfortable. Such silences could also be interpreted as a partial withdrawal from the study as discussed earlier. Consequently, I adapted my interview style to suit their way of communicating with an increased amount of interjections and changes of topic. The shortest interviews (one paired, one individual) were those in the advantaged area where the gatekeeper insisted on “chaperones”, particularly uncomfortable experiences for both the participants and I, as previously mentioned.

The visual methods worked in unexpected ways. Before data collection, I anticipated that the family picture might prompt accounts of family negotiations of smoking restrictions and the floor plans would ensure I had detailed data from each participant about their home smoking restrictions. Instead, the family picture prompted more abstract data about participant understandings of the nature of, and the risk entailed in, SHS exposure (discussed in Chapters 5 and 6). The floor plans were very popular among participants and prompted both the detailed individual data of home smoking restrictions and many of the more concrete and illustrative examples of their personal experiences of SHS and family negotiations, supporting Punch’s assertion that visual and innovative research methods can make the research process more interesting for participants, involve them more and take the pressure of passively responding in “correct” ways to a researcher’s questions (Punch, 2009). Allowing greater time for reflection, constructing floor plans also appeared to put participants in more control of issues they wished (and did not wish) to raise. The accounts given when constructing and discussing floor plans sometimes differed, even contradicted, to the accounts given earlier in the interview or focus group. This led to an analytic complexity that challenges the notion of different methods

“triangulating” data. This will be discussed further in section 4.6.

Reflecting on the researcher role

Mason conceptualises “active reflexivity” as “thinking critically about the way you are doing and why, confronting and often challenging your own assumptions, and recognising the extent to which your thoughts, actions and decisions shape how you research and what you see” (2002:5). Reflexivity, and by this I mean the ongoing, thoughtful consideration of the research process as it unfolds (see Finlay, 2003 for an overview), is strongly advocated in qualitative research, in recognition of the researcher role. In Walkerdine’s words: “the researcher is both written into and writes the story” (Walkerdine et al, 2002:181). There are, of course, limits to reflexivity and insight, as we are not aware of how all our thoughts, actions and decisions influence us, or indeed what they are. Attending to power and ethics in a reflexive manner may be the best we can do (Skeggs, 2002).

When reflecting on my role as a researcher I attempted to recognise any similarities between myself and the participants and create rapport and authenticity through a greater shared understanding (Rose, 1997). As a middle-class woman with a Swedish accent and relatively similar in age to participants’ youth workers and parents, at times I was clearly different.

However, even if we had had identity traits in common, such as nationality, age or class background, such similarities do not necessarily guarantee rapport. After all, we cannot assume that we already know others’ perspectives or identities which are not fixed and therefore, neither are the boundaries between the researcher and researched (Mullings, 1999, Valentine, 2002). Indeed, I found boundaries and power shifted throughout the process and with different individuals. For example, participants reversed the interviewee/respondent interaction on several occasions. When children enquired about my own smoking status, which many did, I informed them I used to smoke but had quit a long time ago. Telling them may have made smoking easier to discuss and I believe *not* telling them would have affected our rapport. Many participants were interested in my Swedish background, my family and where I

lived. While I kept the answers brief, I answered questions as they arose and I think this again helped develop rapport with and make the interview experience less formal. As researchers we are part of the world we research and co-produce both data and findings when interacting with participants (Hammersley and Atkinson, 1995) and my brief moments of self-disclosure to these questions may have influenced their responses as will be discussed in the data chapters.

I enjoyed meeting and interviewing the participants and most appeared to enjoy the experience and feel comfortable with me, possibly because I took great care to adopt a friendly and informal manner. Considering the health-related topic, I was concerned that if I adopted a more formal role I would be seen as a (traditional) teacher or health educator that might have consequences for the type of interaction and responses I received. I imagined such roles might elicit more “public” (Cornwell, 1984), “factual” or “acceptable” accounts rather than more personal experiences and views. Purposively distancing myself from any “expert” connotations, I presented myself early on as a student and non-expert. I used my first name, dressed informally, emphasised I was interested in their views and that there weren’t any wrong answers. I hope I showed a genuine interest in them, not just in terms of extracting useful information, but in spending time before and after chatting to them and their friends.

During the interviews and focus groups I refrained from redirecting participants back to the research questions immediately when they strayed off them. Such a role was closely aligned to, if not identical to, the role of the youth workers in the youth club in the disadvantaged area that I recruited most of the participants from. Partly because of the voluntary attendance of children and young people, youth workers try to find ways of managing behaviour different to the more coercive approaches often taken in schools (Jeff and Banks, 1999:96, Stuart, 2005:33) with youth workers perhaps having a more relaxed orientation to discipline than many teachers who often teach larger groups for a different purpose.

This was not an attempt at assuming the “least adult” role advocated by Mandell, a role that entails suspending adult-like characteristics as far as possible (1988). The

least adult role is widely perceived as idealistic and unrealistic (Christensen, 2004, Harden, Backett-Milburn, Jackson, and Scott, 2000) because it is not possible to entirely escape the hierarchical nature of the adult/child relationship that is prevalent in our society (Punch, 2002). Indeed, attempting to assume such a role when working with older children and adolescents in particular may result in an adult trying to fit into teen culture being viewed as an imposter (Raby, 2007:51). Rather, I assumed a role advocated by Mayall, who states that she assumes the role of a different adult who wants to learn from children (2000:122) but still expects an amount of cooperation and respect to be shown. For instance, while I urged a particularly rowdy group to concentrate on the task a few times, I did not intervene when they lightly teased one member as will be discussed later, or when they swapped chewing gum for cigarettes in front of me after the group. The latter appeared to be a direct attempt to check where my boundaries lay.

I also purposively avoided discussion around what parents were “supposed” to do, or any disapproval (or approval) of smoking in general. In this way, I tried to be as respectful, approachable and non-authoritative in manner and appearance as I could (Graue and Walsh, 1998, Harden et al, 2000) while not attempting to abandon an adult identity. Participants still appeared to carefully monitor my reactions by retaining close eye-contact when they shared stories of their parents’ smoking practices and this may have been reflected in their construction of somewhat ‘defensive’ accounts of their responsible smoking practices.

The experience of collecting data in this study contrasted with my previous one in schools (Knighting et al, 2011) in that the participants appeared conscious that my intention was neither to test their knowledge nor to inform them of the harms of smoking or SHS. Power relationships were more fluid than I had expected from much previous literature on research with children. As discussed, the child protection concerns of gatekeepers and their organisations in the advantaged area occasionally presented obstacles to interviewing participants in confidence and this often required negotiation. However, participants were often in control in small but important ways, steering the conversation in other directions, avoiding answering, and choosing ways to participate (albeit from a limited range of options). While I had

attempted to create situations where this might occur, I was surprised by the ways in which many participants particularly, but not exclusively, in the advantaged area would take control of proceedings. Mostly enthusiastic, a few participants clearly expressed when they wished the interviews would end in their body language if not by asking how long the interviews or focus groups would last. This may have been a disadvantage of interviewing in youth group settings. While time might have been less restricted than in a school, participants may also have been more eager to return to normal activities. Within focus groups, some participants effectively silenced others by teasing or excluding them, often in response to certain statements that did not align with the rest of the groups' views or experiences.

4.6 Analysing the data

Analysis began during fieldwork, became more formalised through coding and continued to be refined as I applied discursive techniques to the data set and as I wrote (and rewrote) the thesis chapters. To reflect this process, this section begins with the earliest analysis I conducted in my field notes, transcription and field reports, to proceed with the thematic and discursive techniques I employed in later analysis.

To aid the reflexive process discussed in the previous section and the analysis, I have kept a detailed field diary throughout the fieldwork and analytic process. It contains notes on my impressions of the communities and the visibility of smoking there, the many conversations with gatekeepers around smoking and parental consent, for example. The notes detail the views and experiences of smoking in their communities and SHS exposure in their homes the children would share with me pre- and post-interviews, most notably during familiarisation visits when they would often volunteer information of this kind.

Coupled with the notes taken during the interviews of body language between the participants, the field notes have been a very useful supplement to the transcribed data. Taking into account the criticisms levelled at Childhood Studies in Chapter 3, I always intended to gather more data than verbal accounts as will be described

alongside a full account of the research process later in this chapter. For example, the way in which both children and adult gatekeepers reacted in the advantaged community when they heard I was looking for children with smoking parents illustrated how smoking was viewed in communities.

During the fieldwork, field notes represented my main form of reflexivity, but I attempted to continue this process during transcription, analyzing, presenting and writing as the following sections will demonstrate.

Choosing certain transcription practices is also a first step in analysis, in beginning to organise and think about the data. I transcribed the digital recordings of all interviews and focus groups verbatim, apart from one where the participant asked me to take notes rather than record her interview. While I did not time pauses, or work to strict transcription rules such as those used in conversation analysis, the transcriptions indicated pauses, included inflections (such as “ehm”), laughter, and some body language I noted during the interview, such as the rolling of eyes, eye-contact and whispering between participants. Transcriptions also included my own interjections and questions in full. As far as possible I attempted to reflect the feel of participants’ talk by using any dialect or vernacular language that they used; mainly Scottish expressions such as “didnae” (did not), “cannae” (can not) and “aye” (indicating agreement). There were some challenges in transcription in participants speaking quietly, at the same time, and the sound of the wrappers of the chocolates I brought to the first few groups (subsequently changed to unwrapped sweets) but listening to the recordings several times resolved most of these instances.

The four fieldwork reports for my PhD supervisors during the data collection process with summaries of data and methodological issues as they arose, and presentations of interim findings to numerous audiences represent a further step in the analytic process. At this stage I began to make sense of the data, by comparing participant accounts, and examining similarities and differences in data derived from different methods. I presented interim findings to audiences of CPHS and CRFR at the University of Edinburgh, tobacco control research and practice seminars organised by ASHScotland and later on conferences including CRFR New Researchers

conference, the BSA annual conference and the BSA Medical Sociology conference. Emphasising the preliminary nature of the findings, I invited members of the audience to comment and in so doing they suggested other theories, authors and implications for policy and practice, some of which together have influenced my analysis.

Around this time, I also attempted more structured comparisons and began to code the data using computer-aided qualitative data analysis software (NVivo). I have previously found NVivo a useful tool in organising large data sets and as a way of making the analytic process more transparent in a team. However, this time I became conscious of the way in which coding “fractured” participants’ responses, moved them out of the context of the interaction in which they were generated and for splinters of data to be taken out of context, resulting in potentially problematic and invalid analyses (Riessman, 1993; Ritchie et al, 2003: 229). These concerns were important, as they suggested features, which ran counter to my exploratory aims. To “re-contextualise” statements, I had to keep returning to the full transcript of the interview or focus group to check when it happened and why. As I found reading print-outs of the full transcripts easier than on the screen, I started highlighting and writing analytic points in the margins of the transcripts instead of using the highlighter and note functions in NVivo, eventually abandoning this tool.

My initial approach to coding was informed by grounded theory and involved detailed reading of the transcripts, coding all aspects of the interview, constantly developing new codes (Strauss and Corbin, 1998). Resulting in large lists of codes, this method of coding tended to privilege a more quantitative approach to the themes with a theme being more important if mentioned more frequently, rather than its qualitative importance. Themes were not “emerging” out of the data in my analysis. Rather, I was privileging subjects and themes that my reviews of the SHS literature and Childhood Studies approach had alerted me to, such as smoking restrictions and instances of child agency. For example, I began with the assumption that children are social actors rather than passive beings and looked out for occasions where they discussed agency. The same occurred with the other research questions I had set before beginning the fieldwork. While adapted during it, the main focus of the study

remained the same. Consequently, my analytic approach had a deductive element running counter to grounded theory.

After developing the main codes, I began to develop sub-codes, re-examining codes to examine differences and similarities between participants' accounts. I compared accounts between and within communities, between the younger and older participants, boys and girls, those who stated particular views or had particular experiences, those who smoked, those who did not, those who were quiet and those more talkative and so forth. In this way I looked for patterns and inter-relationships between sub-codes. I also noted which methods the data were derived from and whether the data prompted by different methods (focus group or paired interview, stimulus picture or floor plan for example) differed in any way. My field notes were especially important at this stage, highlighting the increasing importance of exploring the interrelations of the data and methods.

At the next stage of analysis, I developed a number of themes that cut across and interpreted the vast number of codes and sub-codes and then reviewed them, following the thematic analysis stages described by Braun and Clarke (2006). This process generated the following thematic themes:

- disgust and dislike with SHS and smoking
- smoking as risky and morally questionable
- smoking as omnipresent or an anomaly
- smoking stigma by family association
- smoking and the risk-taking it entails exonerated through addiction and stress and/or smoking practices involving dispersal and distance
- place and SHS risk (car, family spaces versus peripheral spaces)
- smoking or SHS acceptance as signifying a more adult identity
- agency and practices of resistance (overt, covert, absence, acceptance)
- smoking, but also cessation, as a cause of family tension

Many of these themes were different in accounts from the different communities. For example, while responsible smoking practices were detailed in most participants' accounts, they excluded more places and people in the advantaged accounts (e.g. smoking on one's own, outside) than in the disadvantaged accounts (e.g. not smoking next to a baby or in bedrooms).

While this analytic process prompted many useful insights, it was also frustrating at times. I felt I was becoming more distanced from the insights I had recorded in my field notes while collecting the data. It was not just what participants said but *how* they said it that interested me. When thematic analysis at the latent level goes beyond what is actually articulated in accounts and begins to examine the underlying ideas, assumptions and ideologies informing accounts, it overlaps somewhat with some forms of discourse analysis (Braun and Clarke, 2006:13) and is sometimes referred to as thematic discourse analysis (e.g. Singer and Hunter, 1999).

DA treats language as an object of study in its own right, rather than just as a medium through which social research is conducted (Fairclough, 2003). The focus is on language as “a medium for interaction” and “one theme that is particularly emphasised here is the rhetorical or argumentative organization of talk and texts; claims and versions are constructed to undermine alternatives” (Potter, 2004:203). DA is constructionist in that it is not looking for true or false statements but that people construct versions of the(ir) worlds in discourse for particular reasons, so well suited to my epistemological constructionist stance. Examining why people might construct their accounts in certain ways rather than others appealed to me as I had begun to notice that many participants' accounts appeared to construct their family smoking practices in particular ways, for example in defending or justifying certain smoking practices which I thought would be interesting to further explore by using elements of the DA approach.

Rather than the very detailed and linguistic form of DA where each word and pause is analysed, I was interested in further informing the thematic analysis with selected elements of the approach as a complement. Because I only used certain discursive techniques for particular themes, I would not refer to my analysis as a ‘thematic

discourse analysis', but instead a thematic analysis informed by DA. I used DA techniques to think differently about the data, examine what participants were trying to achieve with their accounts, which discourses they drew on and chose to the exclusions of others. Two main DA concepts helped me to do this, including looking at participants' *stake* in what they disclosed and the *scripts* they used. Potter explains stake in the following way:

People treat each other as entities with desires, motives, institutional allegiances and so on, as having a stake in their actions. Referencing stake is one principal way of discounting the significance of an action or reworking its nature." (2004:210)

"Scripts" refers to ways in which people construct an event as either belonging to a general pattern or as an anomaly (Edwards, 1997:144). Scripts are often used to describe appropriate behaviour and to assign responsibility or blame. Again, examining scripts proved useful in analysing participants' accounts of family members' smoking practices in Chapter 6 and 7.

In this way, I recoded the transcripts using elements of DA. As before, I carried out detailed readings of each code, highlighted sections of text, and made brief notes in the margins: generating the discursive themes or responsibility, morality and agency. For example, talk about family members' smoking practices often reference the idea of stake. It seemed to me that participants attempted to rework the nature of parents' smoking by detailing the care they took in protecting others and in the control they were said to exercise, so the very opposite of risk-taking, as can be seen in Chapter 7. My thematic analysis had generated a theme detailing the 'controlled' practices of dispersal and distance and of addiction and stress as reasons for smoking, yet these appeared contradictory to some extent. One of the disadvantages of thematic analysis is that it is difficult to maintain continuity within and across accounts, nor does it allow claims about language used (Braun and Clarke, 2006). Examining stake allowed the generation of the discursive theme of responsibility and exonerating responsibility, as both appeared to be meant to achieve the same aim: to rework the idea of irresponsible smoking parents into responsible parents who can't help their addiction but manage the risk in a responsible manner. In this way, using discursive

techniques did not change the analysis substantially but instead complements it and helps to nuance it further.

I also found it helpful to think about what was unsaid, literally as in silences or figuratively as in assumptions. Children's silences and the need to analyse instances of it in a less simplistic way has been noted by Lewis who urges researchers to provide an explicit methodological account of the way in which we "recognise, respond to and interpret" them (2008:19). By stating one's epistemological position to the interpretation of silence, the cultural context of silence, one's response to silence, the immediate statements around the silence and how it is coded and reported in analysis, Lewis claims we can provide a more nuanced account of the child's voice than that which has been forthcoming in much research with child participants to date (2008:19). Accordingly, my analysis of participants' talk is interspersed with participants' silences and my reflections on these and what they might signify. The interpretative challenge of this will be noted in Chapters 5 to 7 and further discussed in Chapter 8, but here I would like to state that silences can have many reasons: participants may feel disloyal, they may feel the question is irrelevant or uninteresting or confusing. Because I moved on when participants were silent, erring on the side of caution in case they were not wanting to answer the question, I cannot compare each account with all others as not all participants answered all questions.

My position regarding the validity of participants' accounts of their views and experiences can be described as a mid-point position on a scale of social constructivism. While I do not consider participants' accounts to be pure social constructions bearing no relation to their perceived reality, as a naïve constructionism perspective might propose, yet neither do I consider their accounts to be windows on their reality. Instead I see accounts as drawing on, and being informed by, reality but also actively selected versions to achieve an effect on the person listening (Williams, 2000). As discussed in Chapter 2, an individual's approach to risk depends on others' definitions of the situation which are in turn based on wider cultural values that surround them, as well as the specifics of the physical environment in which the interaction occurs. Individuals usually wish to

portray a positive sense of self to others so as to negotiate their way through interaction to maintain their own performance but also (to varying extents) the performances of others (Goffman, 1959), a phenomenon that is particularly relevant for accounts generated within a focus group or pair.

Accounts are also co-produced, with the researcher who is actively involved by designing the study, influencing the research encounter and selecting issues to analyse and disseminate (Fairclough, 2003). Accordingly, researcher reflexivity is an important component in any interpretivist account of the research findings and will continue to feature throughout the remainder of this thesis as it has in this chapter. Thus, I am neither claiming that accounts accurately describe what “really happens”, nor that they are fabrications. Their accounts are likely to have been influenced by a host of different issues of which their actual experiences of SHS and smoking in the home is an important one. I use the language of “discourses” and “accounts” when discussing what participants have told me to reflect my epistemological position.

4.7 Disseminating the findings

Although social researchers are often highly committed in principle to the dissemination of research findings, in reality dissemination is often restricted through limited timescales and funding opportunities (Tisdall, 2009). However, conducting the data collection of this study soon after the smokefree legislation and with such debate surrounding SHS has led to considerable interest in the findings. As mentioned in the previous section, I therefore began presenting preliminary findings in informal contexts such as the CPHS and CRFR weekly seminars, STCA, CRFR New Researchers Conference during and immediately after data collection. Since then, I have also presented at the British Sociological Association’s (BSA) Annual Conference, the BSA Medical Sociology Annual Conferences, the Scottish Parliament Tobacco Issues group, to ASH Scotland and NHS Health Scotland. I have disseminated the findings of this study to over 30 practitioner and academic audiences throughout my PhD.

Given the lack of research with children and young people about their views and experiences of SHS, I wanted to ensure that I engaged with different policy and practice audiences as well as academic ones. Within a few tobacco audiences some concern has been voiced that I, in highlighting stigmatization of smoking parents, am “playing into the hands of tobacco companies”. On the whole, however, audiences have so far been enthusiastic, interested and receptive to the messages of the study.

Disseminating to participants of the study was a key part of the dissemination plan. However, when asking participants in what format they would like to hear about the findings, there appeared to be little interest. When the analytic process was complete, the gatekeepers I contacted informed me that very few of the participants were still attending the groups. In future research, I would provide participants with a summary of the interim findings such as the ones I presented in seminars and conferences.

4.8 Conclusions

This chapter has described and reflected on the process of research, from what inspired the choice of methods, research design to the recruitment of participants, adjustments, data collection, analysis and dissemination. It has detailed how, informed by Childhood Studies, I paid particular attention to the processes by which I gained informed consent, protected confidentiality and where appropriate, attempted to dissipate power relationships according to advice on involving children in research (Mahon and Glendinning, 1996, Morrow and Richards, 1996, Christensen and James, 2000).

Based on my experiences in this study, this simplification of power relationships in research can resemble caricature. As with all caricatures there are elements of truth but also elements of falsehood. While it is true that I as the researcher had most power, I was not always in this position. Instead, a higher position of power is something all actors in this process have, at certain points of the process, exercised. Potential participants agreed or did not to participate both initially and also in the extent of their participation within the interview or focus group, gatekeepers agreed

or did not agree to provide access to potential participants and shaped that access in ways that had an impact on the data generated. It has also illustrated how power was fluid and dynamic. At some points in the process, gatekeepers affected the ways in which access to, and consent from, participants was gained and permitted owing to the uneasy balance of my concern about child participation and gatekeepers concern about child protection.

However, I acknowledge that ultimately I hold most of the share as I retain the power in choosing who to study, what to study, what methods to use and how the research should be written up and disseminated.

I have attempted to describe this complex process within this chapter but power relationships to some extent underscore this whole thesis in ways I will, in the following chapters, continue to unpack. I hope to have shed light on many of what appeared “problematic, messy and contested nature of ethical dilemmas when working with children” (Gallagher, 2009:11) and wish to carry on the critical reflection of this chapter into the next three, where the empirical findings reveal the complexity of the co-construction of knowledge. In Chapter 8, I return to many of the themes developed in this chapter to critically explore the implications for developing our methodological approaches and the potential consequences for policy and practice.

Chapter 5: Understandings of SHS risk

5.1. Introduction

As the first of three chapters concerning the empirical findings of the thesis, this chapter presents participants' understandings of SHS and the risk it entails. Next, Chapter 6 examines participants' accounts of how their families attempt to manage the risk of SHS by smoking "responsibly" within their homes and cars. Finally, Chapter 7 attends to participants' accounts of negotiating and resisting family members' smoking. Themes of risk, responsibility and resistance underscore, and overlap in, participants' accounts of smoking in the home and car in these chapters. While the similarities in participant accounts are many, the different discourses that participants draw on will be unpacked and analysed in this and the following two chapters. Alongside this analysis, I will also reflect on the context in which accounts were generated. The three chapters will be interlinked and the contributions, contrasts and contradictions to previous empirical work will be discussed in detail in Chapter 8.

This chapter begins with an analysis of participant accounts of how SHS is experienced and perceived and some of the differences and similarities in accounts between participants from the two communities of contrasting socioeconomic profiles that they were recruited from. It proceeds to discuss what sort of risk SHS is said to entail and to whom, according to participants' accounts.

5.2. Dislike and disgust

All written and verbal information given to the participants prior to and during the data collection phase referred to SHS as "other people's smoke" because of the connotations inherent both in the terms "secondhand smoke" (mainly, that someone else has "used it first" as noted by Brandt, 1998: 168) and "passive smoking" (Chapman, 2003). By using a clear descriptive phrase without too many connotations, I hoped to find out the terms that participants were familiar with, and

that they themselves used. Without exceptions, participants either assumed or asked, if by “other people’s smoke” I meant “passive smoking”.

The data this chapter examines often emerged early on in the focus groups and interviews. I started each interview or focus group by showing participants a line drawing of two adults smoking while watching TV at home in the presence of three children (see Figure 2). Participants assumed they were a family and referred to the woman in the picture as “the mum” and the man as “the dad”.



Figure 2: Family picture stimulus material

At the first mention of “other people’s smoke” or when first introduced to the picture of smoking in the home (Figure 1), most participants employed a discourse and expression of disgust, expressed both verbally and non-verbally. Vivid terms were used to describe smoke; it is “*smelly*”, it “*stinks*”, is “*disgusting*”, “*oily*” and “*chemically*” and the word “*horrible*” featured frequently in these accounts. The

experience of being exposed to SHS was described in a strongly embodied manner with references to feeling physically sick when in the same room or car as someone who smoked, choking/coughing noises and facial expressions of repulsion. Such expressions varied from a wrinkling of the nose to holding noses or in one case, a participant crossing her fingers in front of her face in a gesture reminiscent of one to ward off evil spirits. Participants said SHS was “*mank*”, “*minging*” and something they “*can’t stand*” and described the experience of being in close proximity to a person who smokes in terms of disgust. Feelings of claustrophobia were evoked with breathing in someone else’s smoke likened to “*choking*” and like they “*can’t breathe*” when in a smoky room or car with “*bad air passing around*” with accounts of experiences of being exposed to SHS in cars representing many of the strongest reactions to SHS (see Chapter 6 for further discussion of smoking in cars).

Smell and taste were interwoven in descriptions of experiencing SHS. Smoke smelt so “*bad*” it made one “*feel sick*”. Using a language of disgust, accounts evoked an image of SHS as a pollutant or contaminator of both people and domestic environments. With the exception of some accounts from participants who smoked themselves, discussed later in this section, tobacco smoke was said to “*smell bad*”, SHS was “*bad air*” and houses where smoking was not restricted “*smelt bad*”. Reflecting on her strongly negative response to tobacco odour, Jennifer A14 describes how this response has changed with smoking no longer permitted in public places:

NRD: You mentioned the smoking ban before, can you remember what it was like before that?

Jennifer A14: Yeah, we used to go to this pub on a Sunday or the weekend anyway and I used to love the smell of smoke [laughter] really like it but now I can’t stand it, it’s horrible...

This suggests an element of social construction, of the same smell being constructed positively and negatively with different connotations depending on the place and time. With the smokefree law, and the associated changes to social norms and how SHS is viewed, Jennifer A14 describes the way she goes from loving SHS, to something “horrible” she “can’t stand”. When asked directly about their views on

the smokefree law, few participants responded with more than a brief positive acknowledgement that it was “good”. The data with the first eight participants gathered in 2007 was a little more informative, for example, the smokefree law was seen to contribute to the stigmatisation of people who smoked by one participant (further described in Chapter 7). Most of the data were gathered in 2009, however, three years post-smokefree legislation. Smokefree public places were thus something that participants had grown up with, were used to and may no longer recall what it used to be like before.

Departing from discourses of disgust, three participants in two different groups in the disadvantaged area described SHS neutrally or, on one occasion, as pleasant. These discourses appear to reflect group dynamics to some extent. Accounts of indifference occurred in focus groups where participants appeared to attempt to distinguish and differentiate themselves from other participants who expressed risky accounts of SHS. In a focus group with three girls in the disadvantaged area, Leah D10 and Alexa D10 were friends and clearly positioned themselves as such by sitting close, whispering, and stating that they lived close together. Initially, Lindsay D11 described how deeply she disliked her mother’s smoking while Leah D10 and Alexa D10, on the other side of the table, were quiet, made very little eye-contact with her and appeared not to listen. When specifically asked what they thought of parental smoking, their accounts contrasted significantly with hers.

NRD: What do you three think about your parents’ smoking?

Lindsay D11: EEE-EEE[makes thumbs-down sign] [laughter].

NRD: [laughter] What do you think [to Leah D10]?

Leah D10: Don’t know.

[Leah D10 and Alexa D10 look at each other, then me, and shrug their shoulders]

Alexa D10: I don’t really think about it, I just get on with what I’m doing.

Leah D10: I dinnae really care.

NRD: No?

Leah D10: It's like; they're outside so it doesn't really ... harm us or anything.

Lindsay D11: Well, it does harm me because if I want to get something to eat or drink my mum is always sitting smoking in the kitchen.

[Alexa D10 and Leah D10 whispers something impossible to pick up but my field notes indicate I thought it was about Lindsay D11 at the time].

In saying they don't know and don't really care about their parents' smoking, Alexa D10 and Leah D10 express indifference regarding their parents' smoking in direct contrast to Lindsay D11's clearly stated concern about her mother's smoking and her own SHS exposure. They remove their discursive *stake* in the conversation, making a point of differentiating their opinions and therefore, by extension, *themselves*, from her. Indeed, while Leah D10 and Alexa D10 claimed that their parents never smoke inside, when later drawing their floor plans they indicate that their parents smoke in certain areas of the house at certain times. My field notes reflect on how such dynamics may affect accounts.

When a few other children enter the room and I go over to talk to them, Lindsay D11 says 'We've got chocolate,' and laughs, Leah D10 says 'It's not that funny,' while rolling her eyes. That [dynamic] felt like a sort of subtle 'you are not part of our gang and we won't agree with you on anything no matter what you say'... By saying they weren't bothered it felt as though they were really just opposing whatever Lindsay D11 said, and that if I had interviewed them on their own they may well have said something different.

A similar dynamic, albeit expressed differently, was evident in a focus group with boys, also in the disadvantaged area. Using humour, Mark D13s says he likes the smell of smoke to the amusement of his friends Sean D14s and Lewis D13s. Matt D14 disagrees and the others respond by mocking him:

Mark D13s: We all just sit in the same room smoking. We just go [sniffing the air, pretending to smoke] 'aaahhh' [Mark D13s, Sean D14s, Lewis D13s laughter].

NRD: You like the smell of smoke then? [to Mark D13s but Matt D14 answers]

Matt D14: Nah. I hate the smell. If people are smoking near you it's just [lots of protests noise from other participants]. 'Cause I hate when I go to my granny's, she smokes all the time and when I come home to my hus I'm still smelling of it. And my brother goes: 'Are you a smoker?' 'cause I smell of smoke and I'm like, 'Nah, I've been to granny's.'

Mark D13s: Would your ma think you've been smoking?

Matt D14: Nah, my brother does but I just say no, I've been to my gran's.

Sean D14s: What would your ma do, give you a smacked bum and send you to bed?

Mark D13s: Like you're two year-old or three?

Laughter and humour often punctuated focus groups and interviews, particularly with participants recruited from the youth club in the disadvantaged area like these ones in line with a “culture of humour” in youth clubs also observed by others (Plows, 2010). The function of humour in social interactions can be to build relations, defuse tense situations and relieve stress (Robinson and Smith-Lovin, 2001:123). In this instance, it was multifaceted, testing boundaries in a negative way as well as positive. The others juxtaposed their own smoking – and by implication – less childish identities with that of Matt D14 who does not like SHS, as I noted in my field notes:

Because of Matt D14, who wasn't part of the gang, saying he hated SHS, the others seemed to not want to agree with that and [Mark D13s] deliberately took pleasure in saying how much he enjoyed the smell of smoke, how there were no smoking rules in his home.

Unwilling or unable, perhaps uninvited to take part in the banter, MattD14 became the source of fun and the boundaries between friendly banter and teasing were blurred.

Constantly testing the boundaries of the situation in other ways too, everyone but Mark D14 swore and played with the digital recorder, which, at one point, one of

them threatened to throw out of the window. To the others, Matt D14's dislike of SHS appears to signify a further distancing from them. After this exchange, he said very little and appeared as uncomfortable as I was and the power dynamics shifted markedly away from him as the other three participants who silenced him and took control of the conversation. Matt D14s was not the only one left (presumably) feeling uncomfortable by the exchange, as my field notes attest to.

[The exchange] Made me feel uncomfortable, and reminded me of the focus group with Alexa D10, Lindsay D11 and Leah D10. This was the boy version, direct verbal disagreement and mocking whereas the girls would achieve the same by rolling their eyes and whispering to each other.

In these examples, it is possible that the statements of the participants more peripheral to the social groups may encourage the others to position themselves as more pro-smoking and less concerned about SHS, than had the group been socially cohesive (as recommended by Highet, 2003). Conversely, it is possible that those who expressed a deep dislike of SHS did indeed agree with the statements of others in their groups and pairs. My field notes suggest that the particular dynamics in these two groups did affect accounts in the direction and manner described, however. The field notes also describe a presumed, and stereotypical, gender difference in the way participants disagreed and distanced themselves from Lindsay D11 and Matt D14.

Further, the three boys who teased Matt D14 all smoked. Like the other three participants in the disadvantaged area who smoked, their accounts differed from those who did not. In this context they appeared to ridicule a SHS risk discourse. Overall, participants who smoked showed noticeably less dislike of, and concern about, SHS.

Ryan D14: It feels like you've just swallowed something, swallowed something that's stuck in your throat.

NRD: Yeah.

Ryan D14: When you cough like that it's quite sore.

NRD: What about you guys, what does it feel like when you breathe in smoke?

James D14: [choking noise] [laughter] It's damageable.

Thomas D15s: When you've smoked so long ye dinnae notice...

Leaning back and smiling, Thomas D15s refers to his smoking status to explain why he does not react in the same way to SHS as his non-smoking friends who gesture towards their throats and make choking noises talking about SHS. Yet, initially, he expressed a different opinion of SHS, an opinion quickly challenged by the others based on his smoking status (not yet revealed at this point):

NRD: Ok, first of all, let me start with a stupid question...

Ryan D14/Jamed D14/Thomas D15s: [laughter]

NRD: Say I had never ever seen or smelt a cigarette before, the smoke from a cigarette, how would you describe it?

Ryan D14: Unpleasant.

NRD: Unpleasant, ok.

Thomas D15s: Aye, I hate it.

Ryan D14: You smoke! [laughter]

Thomas D15s: It's the truth, though.

NRD: [laughter] Yeah I know even if you smoke yourself ... I used to smoke myself and I still thought it was horrible: the smell of other people's cigarette smoke.

Despite appealing to the validity of his statement here, Thomas D15s did not express any further concern or dislike of SHS. Instead, he said James D14 smoked, despite James D14's assurances to the contrary and smiled to himself when Ryan D14 expressed his strong dislike of his father's smoking in a mildly mocking manner reminiscent of the way in which Mark D13s and Sean D14s talked to Matt D14 in the example above.

My own interjection in this discussion was motivated with a wish to build rapport and “save face” on Thomas D15’s behalf. The benefit of researcher self-disclosure in interviews and focus groups has been subject to debate (see Chapter 4). My field notes testify to the ways in which I believe it benefited rapport in this study generally and especially on this occasion, by reversing any image they had of me as a health educator/teacher role.

I think Thomas D15s thought I was there to educate them about the ill effects of smoking. Once I had mentioned I used to smoke he appeared to visibly relax and not watch his answers. But in the beginning he said he hated smoke. Maybe he did, but it was as if that was the answer he thought I expected. Also, when Ryan D14 talked about his Dad smoking despite Ryan D14’s asthma I felt him looking carefully for my reaction.

Retrospectively, I wonder whether I should have been so quick to step in as it would have been interesting to see how they resolved the apparent contradiction in his account between themselves. This instance clearly illustrates the co-production of accounts, when participants challenge or agree with each other and when researchers interject, changing the course of the conversation and thereby the data. Like these participants, many others appeared to carefully monitor my reaction to their accounts, particularly when any of them revealed they (or one of the other participants) smoked or that their family members smoked in the home. However, as the data collection progressed, and I, to my knowledge, did not react with anything other than interest, such vigilance appeared to level off and accounts would alter slightly. While perhaps particularly pronounced on this occasion, other participants’ accounts were also ambivalent and would change from a very clear anti-smoking position to something more nuanced or even ambivalent.

Accounts from the advantaged area diverged in an important way from those in the disadvantaged area. In discursive terms, their smoking *scripts* differed. As explained in Chapter 4, scripts refer to the ways in which events or behaviour are part of a general pattern (Edwards, 1997:144 in Silverman). Participants from the advantaged community most often only had one member of their family who smoked and framed smoking as an anomaly in their accounts. For example, Jennifer A14 positioned her mother, who smoked, as different from others in her family and social circle:

NRD: Does anyone else [but your mother] in your family smoke?

Jennifer A14: My godfather smokes but no, my mum is the only one, really. Think maybe my aunt smokes but she doesn't stay here. Mum is always the only one who goes outside. They have one or two friends who smoke but they go outside too and everyone else just thinks they're ... not stupid, but you know, no one else ever does it even if they used to. My dad used to smoke cigars I think, but not anymore.

NRD: What about your friends' families?

Jennifer A14: No, only my mum [rolls eyes] I wish she would stop.

Here, smoking is framed as an unusual and outdated practice that “no one else ever does ... even if they used to”. By saying it is “not stupid, but you know” she appeals to a shared social understanding of smoking being unwise and disapproved of. As in this account, the anticipated disapproval of others often feature in others smoking scripts from the advantaged community. Smoking is not the norm. Indeed, when participants talked about their sensory reactions to SHS, some of those from the advantaged area talked about any amount of smoke, even outside, being “suffocating” and “horrible”, even walking past people who smoked outside (see Chapter 7).

In contrast, the script regarding smoking evident in the accounts from participants in the disadvantaged community was that it was the norm, to be expected. In contrast to participants in the advantaged area, participants from the disadvantaged area only talked about people in close indoor proximity smoking with closed windows as “mank” or “choking”. Invariably, understandings of bodies and bodily sensations are related to the social contexts participants inhabit with these, in turn, related to wider socio-cultural discourses regarding how bodies *ought* to act and feel. Reporting that most of their family members smoked, smoking was a constant presence in their everyday lives.

NRD: Who smokes in your family?

Lewis D13s: My mum, my dad...

Sean D14s: Your sisters and your brothers.

Lewis D13s: Everybody, everybody!

Sean D14s: My mum, my dad, my sister, my sister, my brother...

NRD: Everybody?

Lewis D13s: 'Me' ([meaning Sean D14s]). [laughter, looking at me][Sean D14s pauses] You used to [smiling at Sean D14s].

NRD: Yeah I'm not going to say anything to anyone about who smokes here, that is confidential.

Sean D14s: Me, my nana, my cousin, my mum, my uncle, my auntie does. Everybody smokes in my family.

Similar to the boys in this focus group, most participants in the disadvantaged area listed numerous relatives and friends who smoked. Further, six participants also either volunteered that they smoked, or did not dispute the fact when the information was volunteered by others like Sean D14s above.

As outlined in Chapter 4, the visibility and evidence of smoking was strikingly different in the areas. In the disadvantaged area, smoking was highly visible, a constant presence with people smoking on the streets and outside pubs, shops and the community centre I recruited participants from (also noted in Martin et al, 2008). With cigarette butts piled high outside bus stops and other public places, reminders of smoking were everywhere. In contrast, despite pubs, cafes and restaurants in the advantaged area having gardens or access to outdoor spaces with ashtrays that people who smoked would be able to use, very little smoking took place on the streets and there was very little evidence of it in the form of cigarette butts on my visits there. Indeed, recruitment in the advantaged community was challenging because so few children had adult family members who smoked. While I found a few potential participants in each group in the advantaged area whose parents or close family members smoked, the way in which potential participants responded to my initial approach is notable.

Unlike in [the disadvantaged area] where most children and young people I spoke to had lots of relatives who smoked, most participants in the advantaged area either don't have relatives who smoke or if they do, then only one or at the very most two. Another difference is that I needed to ask directly if they had relatives who smoked whereas the participants in the disadvantaged area would volunteer that information once they knew what I was interested in. I don't think they were embarrassed as such ... but still, it's just the norm in [the disadvantaged area] whereas in [the advantaged area] it's an anomaly. And when they do 'admit' to parents who smoke they are so quick to point out they only smoke outside or are trying to quit. One girl even whispered that her father smoked while looking around her so that no one else could hear, as if admitting to her father using drugs.

The hesitance surrounding the identification of potential participants in the advantaged community, both on behalf of gatekeepers and on behalf of children whose parents and other close family members smoked, was not an issue in the disadvantaged area. Indeed, when I first approached gatekeepers and enquired about talking to children whose parents or other close family members who smoked, one gatekeeper used the needle in a haystack metaphor to assure me how unusual finding a child *without* close family members who smoked would be.

5.3 The extent of SHS risk

Understandings of SHS and any risk it entails appeared directly linked to, and at times blurred with, understandings of the risk of smoking. In disentangling these, conceptualisations of smoking risk appear better rehearsed and participants visibly relaxed when discussing them. Talk about SHS, in contrast, was often accompanied by participants looking around to me and peers for reassurance and confirmation. Ideas about SHS appear shaped by health education messages received through TV advertisements, the “smoking kills” slogan on cigarette packet warnings and the most memorable parts of school health education with the risks most frequently mentioned were those that were the most serious. There is a distinctly abstract content to some statements, with participants repeating sound bites and extrapolating health education about smoking to SHS, blurring distinctions between smoking and SHS risk by drawing a direct parallel between them.

Smoking was seen to contaminate bodies. Using a symbolic life event such as the

high school prom, Amber D10 outlines a risk trajectory where a “nice” (perhaps pure and good) body is, over time, turned bad by smoking affecting everything:

... all smoking does to you is give you bad lungs, bad teeth and everything else, it makes your whole body, like your whole body is all nice and everything ... like at their high school prom or something, and they start smoking your whole body will be like, not the same and it affects everywhere on you and makes your skin go all scaly and ...

Amber D10, substantiated her understanding of smoking risk by referring to personal experience of the risk of smoking:

Amber D10: Smoking gives you bad lungs and it can give you infections 'cause my Nana died from smoking.

NRD: Did she? What did she die of?

Amber D10: Smoking.

NRD: Was it like... cancer?

Amber D10: Ehm, don't know.

Uncertain of the precise illness, Amber D10 was certain that her grandmother's death was directly related to smoking. I prompted for cancer, as that was the consequence most frequently mentioned by other participants, for example by Jennifer A14, who translated her school health education directly to her own family and consequently, worried about her mother dying:

Jennifer A14: I'd rather she didn't smoke at all but at least it's outside so it doesn't endanger us

[...]

NRD: Why would you rather she didn't [smoke]?

Jennifer A14: Because of all the risks, she could get cancer. In school [...] they told us that one in six of smokers get lung cancer and die and if she died our family would really be ... there would be a huge impact because she does everything for us, she cooks and takes us to school and is so

important to us as a mum. And if you think of one in six, well there's six of us so sometimes I think that's a really big risk ... then other times I think, it won't happen to her but that's what they said in school that people always think it won't happen to them so that made me worried.

NRD: Do you worry about it a lot?

Jennifer A14: Yeah, it just would have such a huge effect on us if she died.

Jennifer A14 articulates the anxiety applying the epidemiological estimate of risk for people who smoke to her own (non-smoking, apart from her mother) family provokes within her, an anxiety evident throughout most of her account, with her concern for her mother almost palpable.

Consequences of smoking or SHS exposure were otherwise rarely related to experiences of illnesses such as those of grand parents' or own symptoms of SHS exposure. However, respiratory issues appeared relatively normalised in accounts from the disadvantaged community with a discussion after one focus group with girls in the disadvantaged area suggesting a familiarity with respiratory problems and tests associated with asthma as described in my field notes.

Doing the questionnaires [Abigail D10] said she didn't have asthma but then seemed unsure and asked the others what they thought of the test where they had to blow into something as hard as they could. They all said it 'wasn't a very nice test' and then they showed me their inhalers which [Abigail D10] also had. I said 'but you don't have asthma?' and she said she didn't think so. But she talked about her last inhaler being a horrible colour and this one had stickers on it which looked like they had been there for a while so looked like long-term use of it rather than short-term.

Some participants mentioned their families took particular care not to smoke around children with asthma, which implies that they associated the exacerbation of asthma symptoms with SHS, but accounts never specified the link between SHS and asthma beyond this. Any harmful effects of tobacco smoke did not appear to be perceived to last on surfaces or people beyond the time of direct exposure, as suggested by Taylor D14, who distinguishes between the effect of smoking in the presence of others and not:

[My aunt and cousin] don't smoke around me, which is really good. Say we were at a party, if it was a children's party, they'd probably smoke but they would go outside. They wouldn't smoke inside while everyone else were there. [...] So it doesn't disturb the children and stuff. So they don't get covered in it, like smell of smoke [laughter].

Similarly to Jennifer A14, several other participants also talked about bringing the health education messages they received in school home in attempts to persuade their parents to stop smoking (further explored in Chapter 7). Drawing on such school health education messages, participants detailed the abhorrent contents of cigarettes and the adverse consequences of smoking.

NRD: You know how you said about inhaling smoke, what do you think it does when it comes into your body?

Jack A11: We saw these - had these pictures at school when we did a subject on drugs and there was like a picture of a healthy person's lungs and there was a picture of these black shrivelled up lungs which was the lungs of a smoker...but also we got... this person coming in first year with a big box with a glass thing over it and a jar full of tar and it was how much tar had emerged from a cigarette and rat poison and stuff like that [...] You wouldn't, you wouldn't just take rat poison or inhale tar so [laughter].

In comparing the choice to smoke with taking the risk of poisoning or inhaling toxic substances not fit for human consumption, Jack A11 points out how fraught with risk and deeply irrational smoking appears. Continuing the theme of disgusting and dangerous substances, Catherine A13 and Melissa A12 recount this message and also another repeated by several other participants: that smoking one cigarette reduces your lifespan by a very specific amount.

Catherine A13: We got told that every cigarette that you smoke takes away 11 minutes of your life, apparently.

Melissa A12; And there's sewage and stuff in them [pulling face].

Catherine A13: Well, 'cause it's got, like, we got like a talk about smoking and they had a jar with like what's inside it and it was like chemicals and sewage [laughter].

NRD: Lots of things that aren't ...

Catherine A13: good for you.

Melissa A12: Yeah like gases from things.

Frequently, participants framed SHS risk accordingly. When I interviewed Chloe A11, for example, she, like many others, appeared more comfortable talking about the risk of smoking than SHS. When I steered her back to the topic of SHS, she framed the risks in relation to smoking:

NRD: What about other people around people who smoke?

Chloe A11: Passive smoking? It's a bit like you were smoking yourself, you could die as well.

NRD: You could die?

Chloe A11: [brief pause] It's more chance if you ... if you're smoking.

Chloe A11 hesitates when I repeat her assertion that you could die (in a neutral manner) and introduces the caveat that smoking entails an increased risk. While well rehearsed in the risks of smoking, participants appeared significantly more uncertain about the specifics of SHS risk. A few participants stated that SHS exposure posed a greater risk than smoking to health. When looking at the stimulus picture, Jenna D15s talked about the children in the picture as having “worse” lungs than her parents who both smoked:

Passive smoking is just worse than normal smoking, so their lungs are just gonnae be worse than my mum and dad's.

However, a discursive pattern akin to Chloe A11's above became much more familiar where participants would repeat versions of the “Smoking Kills” health education message with confidence; apply this to SHS; then hesitate or even retract it when asked to confirm, clarify or elaborate.

In contrast, the risk associated with smoking, was talked about relatively confidently, more spontaneously and was applied directly to their own health and circumstances. For example, the perceived negative impact on fitness was given as a reason not to

start smoking by Jack D10.

Jack D10: [Don't think I'll start smoking] 'Cause I'm fit as it is.

NRD: [laughter] You're unfit as it is? Fit? [Jack D10 nods and smiles] So you wouldn't want to smoke?

P30: 'Cause what if you come down ... 'cause I'm gonnae do a race this year with him [P31].

NRD: Oh right, like a competition, a race.

Jack D10: A race.

NRD: Cool, so you wouldn't want to make yourself ... [Jack D10 pulls an exhausted face] [laughter].

In a paired interview with Rebecca D14 and Jenna D15s, the girls discussed fitness and smoking from different perspectives but arriving at the same conclusion: smoking makes you unfit:

Jenna D15s: you get unfit [from inhaling smoke] 'cause like, see when I started smoking I was kinda fit and now I'm quite unfit.

[...]

Rebecca D14: ...I just din'nae like [smoking]. I've tried it but I would never do it again.

NRD: No? [laughter]

Rebecca D14: [laughter] 'Cause like, I wanna be a fitness instructor and like if I started smoking I could'nae be that 'cause I wouldnae be healthy ... if I was taking a class I'd be like [huffs and puffs] [laughter].

In these extracts, Jack D10 and Rebecca D14 discuss the risk smoking involves of impeding their future chances of performing well at a race and becoming a fitness instructor, and Jenna D15s talks about her experience of becoming less fit since starting to smoke. By applying the risk smoking entails to their own circumstances and lives, participants engage with the risk discourse that is, at first, not nearly as

present in their accounts of SHS risk.

In accordance with health promotion/tobacco control discourses, however, nearly all participants framed SHS as a risk to health, albeit mostly with more caveats than smoking. Direct references to risk and responsibility were made when participants said what occurred in the stimulus picture was “*risky*”, a “*hazard*” and “*irresponsible*”. Specific risks were rarely mentioned and almost never without prompting. While most were aware that it affected respiratory health negatively they would say it gave you “*bad lungs*” rather than exacerbated asthma for example (apart from Anna A12 who said it was “*really bad for my sister’s asthma*” above). A few participants mentioned cancer and cardiac health but again, in a general manner, like Jenna D14: “*If you’re around smoke, it affects your heart*”, or like Jennifer A14:

Jennifer A14: It really isn’t fair of them to smoke in a family area like that, they should smoke on their own somewhere else where they aren’t putting their family at risk

NRD: Risk of?

Jennifer A14: Cancer, you can get cancer from passive smoking and it’s just really not good for you, or for them smoking.

In asserting that SHS is “*just really not good for you*” Jennifer A14 simultaneously sums up the certainty that it is harmful and the uncertainty about any more specific reasons why it is. SHS was described as something very unpleasant and risky, a contaminator of bodies, but one that appeared manageable if contained. Such understandings appear partly derived from two SHS health education TV adverts referred to in passing by a few participants (“*that advert with the baby*”). One of the adverts depicted a stream of smoke encircling a baby’s neck, the other a stream of smoke surrounding older children sitting chatting at a party. Some of the ideas about SHS can be traced to the visual imagery presented in the adverts. For example, by usually focusing on babies, adverts communicate that small children are especially at risk. The smoke noose and clouds of suffocating smoke communicates that SHS is very risky but also that what is risky is visible and the streams of smoke could be

misunderstood as smoke not being everywhere but contained within such a stream. Visibly dispersing smoke, by opening a window for example, is rational if based on such an understanding.

Some of my early data collection and analysis focused on what participants *knew* of SHS and focused on possible gaps in their understanding rather than on what they understood. Questioning and probing precise outcomes of SHS exposure and an undue focus on objectively verifiable data prompted much less rich data, where participants appeared anxious to give the “correct” answer. The extract from my field notes below, written after interviews with Lauren A13, Jessica A12 and Chloe A11 in the advantaged area, illustrate my growing realisation that this approach was not best disposed to prompt accounts of participants’ more concrete conceptualisations of risk.

Chloe A11 appeared to find it difficult to describe what SHS is and how it affects people. Like the previous participants here I got the feeling she was guessing about the impact of SHS – trying to remember what SHS does – saying ‘it can kill you’ but when I repeated that she retracted it a bit. I got the feeling she was carefully monitoring my reactions to what she said, like the previous participants in this area (Lauren A13/ Jessica A12) almost trying to be correct and second-guess what I would like to hear a little with the knowledge based questions.

This exemplifies the very situation I had attempted to avoid by choosing focus groups and paired interviews as methods. While it may not be possible to circumvent the hierarchy of power inherent in both adult/child and the interviewer/interviewee interaction altogether, I had taken several steps to redress it. As described in Chapter 4, the interviews with Chloe A11, Lauren A13 and Jessica A12 were conducted in the company of adult chaperones. After having two male chaperones present while interviewing Lauren A13 and Jessica A12, I explained the importance of privacy to the gatekeeper and she agreed to let me be accompanied by one female chaperone well known to the participant during the interview with Chloe A11. Despite carefully preparing this chaperone prior to the interview by explaining the purpose and realities of research and asking her to remain in the background, she did not quite follow my instructions as I described in Chapter 4. To some extent, Chloe A11 and my attempts to subvert the power this chaperone had succeeded. Notwithstanding

my efforts to ignore the presence of chaperones, at one point even jokingly instructing the participants to pretend they are “not here”, interviewing with chaperones present affected all of us. The sense of surveillance from the chaperones who were other parent helpers, who knew the girls parents, is likely to have contributed to a reluctance to share personal views and experiences, so answers were distinctly abstract focusing on official risk accounts rather than accounts of family interactions regarding smoking in the home. It was also an uncomfortable experience for me as an interviewer where I was acutely aware of how the presence of observers affected the girls’ accounts but felt powerless to insist on greater privacy until the second interview (and then unsuccessfully). I also felt under observation and consequently did not develop much rapport with the girls, aware of the ethical conflict of having observers at all, let alone ones who could potentially report back to participants’ parents (although I stressed the confidentiality both prior to and during the interviews) and was forced to take more of an official role asking less about families than in unobserved interviews. These interviews resembled truncated question and answer sessions with awkward silences and embarrassed giggles. Consequently, understandings of risk appeared mediated by context of being observed, making accounts less personal in nature than others were.

In later interviews and focus groups, participants took the lead more and appeared to shape their own accounts more than in these two interviews. In contrast to the uncertainty that characterised accounts of the way in which SHS affected health present in most participants talk, the message that SHS exposure is detrimental to the health of babies was stated with conviction. While older children were said to be at some risk from SHS by some participants, the association with very young children and pregnant women was stated unambiguously:

Anna A12: I don't think it's really good when people are smoking like that 'cause children can inhale all the smoke.

Catriona A13: She's [indicating the woman in the picture] not pregnant when she smokes; you're not to do that.

Anna A12; Yeah, you're meant to stop 2 weeks before you smoke, that's it if you're a teen mum, like if you're a teen mum. I watch too many

documentaries!

NRD: [laughter] So if you're pregnant what can the smoke do?

Catriona A13/Anna A12/Emma A12: Not good, the tar in the smoke, it's not good.

NRD: What about if you're not pregnant?

Anna A12: It's still bad, 'cause the baby can't exactly cover its mouth, it can't like cough and ...

Catriona A13: if you're breastfeeding the baby gets it through that. I know that ... so if you're breastfeeding it's bad for your baby.

NRD: So breastfeeding or if you're pregnant but what about when the baby is out and drinking other milk?

Catriona A13: It's not

Emma A12: not good

Catriona A13: if you're still smoking near it

Anna A12: it's a health hazard the smoke.

Unable to cover their mouths, cough or walk away, the onus was placed on adults and parents in particular to protect babies in participants' accounts. With less developed lungs and respiratory systems, babies were less well equipped to "cope" with SHS:

Jenna D15s: And the windows and the door are shut and the smoke will just stay in the room again and they'll [kids] will start breathing it in and it's worse for a baby

Rebecca D14: on the knee.

NRD: Why do you think it's worse for a baby?

Jenna D15s: 'Cause our lungs are bigger and babies are still developing, I just dinnae think you should.

Unlike the risk associated with smoking, the risk associated with SHS did not appear to be framed as absolute. Instead it was contingent on the perceived vulnerability of those exposed. In these examples, as in so many other discussions, a language of morality (good and bad) was used to describe SHS and smoking practices, with putting babies at risk clearly framed as “bad”. Protecting babies from SHS is presented as a moral imperative: “*you are not to*” smoke when pregnant, “*it’s not good*” and participants say they “*just dinnae think you should*” smoke near babies. A moral discourse was particularly strong when talking about smoking in pregnancy that was frequently said to be a particularly vulnerable time when unborn children could be affected by SHS or even die:

Julia D11: You especially don’t want to smoke when you’re pregnant ‘cause all the smoke will damage your lungs and affect the baby and the baby can die in your tummy, or when it comes out and it’s a bit older, it will smoke and it could die of smoking.

Robbie D10: Lots of people are pregnant and they dinnae know ... so their babies could die or ...

Similar assertions were also made in two other focus groups, both in the disadvantaged area, but in a rather different manner indicative of both the dynamic of the groups and illustrative of the grave risk SHS poses to babies:

Sean D14S: It smokes! [pointing at baby]

NRD: Yeah? The baby? What do you think about it?

Sean D14S: That baby isnae safe, with the smoke ... and the cat. They can die! [mock fright and laughter].

Matt D14: When other people are smoking in the room you can get breathless and stuff like that.

NRD: Breathless, and what did you say you can die?

Mark D13s: Cancer!

Lewis D13S: That bairn [pointing at baby] even though it’s not smoking there’s a helluva lot of smoke there so it can choke after a while and die.

[laughter]

Here, LewisD13S, Sean D14S and Mark D13S's laughter and exaggerated fright when making the claims appear to mock the idea that SHS exposure could have serious consequences. Matt D14 injects with a less serious consequence about getting breathless which then spurs the others on to make claims of a more exaggerated nature. A similar brief dynamic occurred in another focus group:

Rachel D13S: And that's minging 'cause they're smoking beside a baby. Or a cat. And it could die of passive smoking. [laughter]

Danielle D14: And the baby only looks a couple of weeks old! [high-pitched at the end] [laughter.]

As mentioned, few participants mentioned personal experience of parents or grandparents whose health had suffered because of smoking. It may be that the mocking of the "smoking/SHS kills" message in these two groups was due to a disjuncture between this risk discourse and their own lived experience when most people around them are smoking and are still alive. Regardless of focus group dynamics and mocking of public health messages in general, the message that babies are at particular risk permeates accounts, representing one of the strongest themes of risk, never questioned. Conversely, there is an assumption that older children are at much less risk of tobacco smoke contamination unless they smoke themselves in many accounts, mainly because of their comparative physical maturity but also because of their relative agency. The following excerpt from a paired interview with two boys in the disadvantaged community (whom I had just shown the stimulus picture) illustrates this.

Jack A11: Well, they [pointing at older children] kind of seem a bit ... [pointing at the boy, then the girl in the picture] he kind of seems a bit almost embarrassed she's glaring at her dad ... the cat seems content [laughter].

NRD: And why do you think they seem to be glaring or embarrassed?

Michael A12: Because there's like a baby right beside them and they're smoking and it can inhale all the smoke.

NRD: Ok, is that ...not a good thing or ...

Jack A11/Michael A12: That's a bad thing.

NRD: And why is that a bad thing do you think?

Michael A12: Because it's not very good for smoke to inhale into you.

Jack A11: Also there's a difference if you smoke a lot.

NRD: Mmm it makes a difference how much people smoke, and around children ... you were mentioning the baby what about the older children, would it be as bad for them to be around smoke or ...

Jack A11: It'd be different ...

Michael A12: Yeah, I think so.

Jack A11 and Michael A12 also associate SHS risk with how much people smoke, distinguishing between those who smoke “a lot” and those who do not. In another paired interview, Lauren A13 and Jessica A12 similarly distinguish between babies and older children and also introduce the idea of proximity to the person smoking as a risk distinction.

NRD: You were saying with the baby being on his lap it wasn't so good?

Lauren A13: Yes.

NRD: Why is that?

JessicaA12: Because they're so young.

Lauren A13: Because they can't take that much.

NRD: What do you think happens to them, because you said they can't take that much smoke?

Lauren A13: It's not good for their lungs.

NRD: Right, ok. Is that just for babies?

Jessica A12: It's for younger people too ... when people had it when they were younger [pointing to young people in the picture].

NRD: Ok ... is it as dangerous for younger people as it is for babies?

Lauren A13/ Jessica A12: No.

NRD: Why is that?

Lauren A13: 'Cause their lungs are smaller.

NRD: Ok.

Lauren A13: [shrugs and smiles] I think.

SHS risk was therefore not just contingent on the vulnerability of those exposed but on proximity and extent of consumption to, and of, those who smoked. Robbie D10 also pointed to another factor contingent on how smoke can be managed better.

Smoking next to a baby is bad. And they've no opened a window. And the doors are closed.

Participants from the disadvantaged area often suggested dispersing smoke by opening a window or door was sufficient to manage the risk of SHS and to remove the smell of smoke. Consequently, smoking in peripheral spaces such as the kitchen, hall and conservatory was regarded as relatively safe smoking practices, as discussed in the next chapter.

A few participants made further distinctions between the smoke emanating from people who smoke and that from cigarettes smouldering in ashtrays, with the latter considered more risky:

And the smoke from that [ashtray] is even worse for it [baby]. (Lauren A13)

It may be that SHS exhaled by someone was perceived as less harmful because some of the smoke would have been consumed by that person rather than released freely from the ashtray, but participants did not elaborate on these statements.

While all framed SHS as a risk to the health of children, most did not position *themselves* as at much risk. This may be because they wished to distinguish themselves from babies and toddlers by presenting themselves as more mature and less vulnerable. Eleven participants said they had asthma; yet only Ryan D14 and Rebecca D14 mentioned this in the context of heightened sensitivity to SHS and described parents taking precautions and/or asking others to because of it. Robbie D10, Chloe A11 and Lindsay D11 were the only participants who directly referred to the risk to themselves when their parents smoked near them, either indirectly like Chloe A11 by saying her father smoked outdoors to protect her and her sister or directly like Lindsay D11 whose assertion of SHS risk was made in response to Alexa D10's downplaying of it, however.

Later on, Alexa D10's floor plan showed her father smoked in the kitchen and sometimes in the sitting room. This brief exchange illustrates the way in which participants might simplify or edit their accounts to make a point, perhaps particularly when what they said could have implications for how their parents came across to me and the others in the group. Another reason Alexa D10 changed her account is the place in which her father smoked: the kitchen rather than the sitting room or bedroom, a space viewed as safe, or safer, than others (further discussed in Chapter 6).

5.4. Conclusion

This chapter has demonstrated the embodied discourse of dislike and disgust participants spontaneously employ when first asked about SHS exposure. I have analysed the occasions when participants do not employ this discourse and express indifference. Such indifference can be understood in several ways. In this chapter I suggest it can be informed by participants' own smoking status but also by the group dynamics in certain focus groups. Dynamics clearly affected participants and their accounts. I have therefore chosen to interweave field notes in the text to contextualise accounts within the relevant interaction. The way in which participants use humour, agree, disagree, mock, tease, and ignore each other and my own reactions and interjections illustrate both the co-production of accounts and social

norms; what is “sayable” and what is not. This first data chapter has illustrated the analytical challenge posed in analysing accounts and their situational nature.

Unlike some previous research with adult participants, participants appear to associate SHS with risk and did not discount it. Nonetheless, they were often uncertain as to the specifics of such risks and to whom they applied. While drawing on the more familiar smoking risk discourse in their accounts of SHS risks, some important differences are evident. While smoking is conceptualised as an absolute risk to everyone who smokes, this message is also mocked by some and the risk SHS entails is framed as significantly greater to vulnerable groups such as babies, pregnant women and those whose respiratory systems are either immature or compromised by asthma or those who cannot protect themselves. A moral discourse was evident in participants talking about “what people ought and should do”. This moral theme will be developed further in the next two chapters but it is notable that participants view attempts to manage SHS risk and protect others as having consequences for an individual’s moral fibre in accordance with previous research (e.g. Holdsworth and Robinson, 2008).

Most participants’ concern is for younger siblings and their smoking family members’ health and they appear not to include themselves or other older children in a “vulnerable” group. In resisting the idea of themselves as vulnerable to such a risk and withstanding it to some extent, some participants appear to differentiate themselves from younger children. Concurring vulnerability to SHS may be resisted as contradictory to a new and mature identity, illustrating how risk management and immunity can be used as a “technology of the self” (Kelley et al, 1998) in interaction and as “face-work” (Goffman, 1959). Expressing dislike of SHS or concern about being seen as a smoker is resisted with Sean D14s and MarkD13s teasing MattD14, implying that he is more childish than them.

Understandings appear shaped by health education messages received in school about smoking and extrapolated to SHS and, in a few cases, two TV adverts about smoking around children. Such understandings are distinctly abstract in nature, with participants repeating sound bites and extrapolating health education about smoking

to SHS, blurring the distinctions between smoking and SHS risk by drawing a direct parallel between them at times. In this way, they appear to repeat health promotion discourses rather than applying them to their own circumstances. The brevity of initial statements of risk, followed by uncertainty when prompted to elaborate or clarify and looking to others for confirmation, supports this analysis.

Participants position themselves and their views in order to align or differentiate themselves from others in their groups, or, where the presence of adult chaperones appeared to constrain rapport and as a consequence, their accounts. However, more similarities than differences are evident in risk accounts across participant accounts.

Concrete and embodied accounts of experiencing SHS contrasts with the distinctly abstract way in which participants discuss the risk they associate with it. The family picture and the initial questions about what SHS is like prompted very few accounts of everyday experiences of SHS exposure in their homes and cars. Such accounts were more frequently prompted by the floor plans participants drew of their homes, discussed next in Chapter 6. There, I will explore how some of participants' risk understandings are derived from the perceived protective smoking practices of parents and other family members.

Chapter 6: Responsible smoking practices

6.1. Introduction

The purpose of this chapter is to examine participants' accounts of whether, where and when their families smoke in their homes and cars. In part, it overlaps in its concerns with Chapter 5, in that it also explores accounts of risk. However, while Chapter 5 discussed embodied experiences of SHS and more abstract understandings of SHS and risk derived from "official" health education channels, this chapter concerns participants' talk about how SHS risk is managed within the home and car environment. In other words, this chapter discusses concrete everyday responses to SHS risk in the form of home and car smoking restrictions.

The chapter begins with a discussion of accounts that detail the individual, family and community consistencies and inconsistencies in smoking restrictions and conceptualisations of smokefree homes. In detailing how smoking is restricted, individually spatially, temporally, and so forth, this chapter continues to demonstrate the fluidity of power in the data collection and discuss the multifaceted nature of participant accounts detailed in Chapter 5.

6.2. "Safe" peripheral smoking practices in the home

Most participants claimed their homes were subject to robust smoking restrictions or were smokefree, although smokefree did not always refer to homes where smoking did not occur anywhere inside at any time. In the course of the interview or focus group, somewhat contradictory accounts were given of homes where smoking occurred albeit at particular times or places. Such places were all on the periphery of the house, such as the utility room or the kitchen, and at specific times, such as late at night. What was considered robust restrictions also varied in the accounts participants from the disadvantaged and advantaged area. In the advantaged area, only minor spatial and temporal lapses to smoking restrictions in the home were reported, whereas in the disadvantaged area, smoking on the periphery of the home

in family spaces like the kitchen and hall was still defined as a (near) smokefree home. For instance, at first Abigail D12 stated that her mother did not smoke inside their home. As her narrative unfolded, it became clear that she meant that smoking took place on the periphery of the home such as the kitchen or the hall.

Abigail D12: [When mum smokes] She goes in the hall or out on the grass or in the kitchen ... mostly in the kitchen [pointing at the kitchen in her floor plan].

NRD: Why do you think she does that?

Abigail D12: To save us getting hurt ... she doesn't want to smoke in the house 'cause it can damage our lungs.

Despite stating that her mother smokes in the hall and the kitchen, Abigail D12's account reverted back to stating she doesn't smoke "in the house", suggesting that smoking in the kitchen is constructed differently from smoking in the sitting room, for example, and has different connotations. Similarly, Jennifer A14 firstly states her mother "always goes outside – never smokes in the house" then develops a more nuanced account where her mother smokes in the kitchen, albeit only in certain circumstances and, importantly, when the children are absent:

Sometimes if she comes in from a night out like at midnight when we're not there ... you see, I can't sleep, I'm a bit of an insomniac and when I go down to the kitchen and she's there she might be smoking but only once we're in our beds, she doesn't know that I'll be up wandering, otherwise she stands by the kitchen door or sits at the garden bench.

Here, Jennifer A14 validates this flouting of the normal smoking restrictions by drawing attention to the exceptional time of day, occasion (a night out presumably not happening every night) and her presence, which her mother could not anticipate, removing much of her mother's responsibility for smoking around a child.

Describing an occurrence as out of the ordinary, she sticks to a smokefree home script in her account. When participants constructed their floor plans, I asked them to note where smoking took place, however unusual that occurrence was so that we could discuss it. Where other participants mostly noted these exceptions on their floor plans, Jennifer A14 did not, further emphasising its exceptional nature. It

appears the physical proximity to the garden makes the kitchen a boundary area, a peripheral “almost outside” room in the home where smoking does not matter, or at least does not matter as much. Making references to opening windows and kitchen doors, the understanding that ventilation removes much of the risk SHS entails is clear.

NRD: What about [smoking in] the living room and the bedrooms?

James D14: No.

NRD: No, why not?

James D14: They don't smoke there 'cause everyone goes there so they don't... just the kitchen 'cause of the windows and that and the conservatory closer to outside.

NRD: Ok so closer to fresh air?

James D14: Yeah.

[...]

Ryan D14: It'll be the room that's got the most ... how do you put it like ... in the kitchen you've got the back door to open and the windows to open so it just goes oot that's what my uncle and that do.

NRD: Ok.

James D14: It goes away.

NRD: 'Cause they open the windows? What do you think that does when you open a window? Does it take away everything?

James D14: What's there it just goes oot.

Thomas D15s: Aye.

As in this focus group, third-hand smoke – the contamination of the surfaces of objects that remains after secondhand smoke has cleared – was only mentioned tangentially and then in the context of how tobacco smoke stained its surroundings,

rather than any harmful effects on health. Either third-hand smoke was not something which participants were aware of, or they did not consider it a risk. Once it became increasingly clear that “smokefree” homes were not always free from smoke, I was careful to clarify that we were referring to the same thing. For instance, in the following interview with Chloe A11 it became clear that our definitions varied:

NRD: [Your father] Always just [smokes] outside and where does he smoke outside, in the garden?

Chloe A11: Yeah.

[silence]

NRD: Every time he needs a cigarette even when you're in bed [he goes outside]?

Chloe A11: Yeah, or in the kitchen with the door and the window opened up.

Ventilation in the form of opening windows and doors appear to be considered to transform indoor space to approximate outdoor space in these accounts. Like Jennifer A14, Chloe A11 did not mark temporal or minor spatial exceptions to the smokefree rules in her floor plan where she instead indicated that smoking only takes place in the garden.

Much of participants' understanding of what constitutes smoking in the home and “safe” smoking on the periphery transpired through the use of a novel method developed for this study: home floor plans. To find out whether and where smoking took place in the home and car, I began by asking direct questions about their family members' smoking practices in the home and then asked participants to construct a floor plan of their home and indicate spatial and temporal smoking restrictions on it. While some of the data discussed in this chapter has been prompted by the smoking in the home stimulus picture previously discussed in Chapter 5, most of the analysis in this chapter is based on accounts participants gave while constructing floor plans of their homes indicating where smoking is permitted.

Catriona A13 explained her father sometimes smoked within the home, but so briefly that it “*doesn't count*”.

If he can't find a lighter he'll light it off the stove but he'll go out to smoke it to the back garden.



Figure 3: Catriona A13's floor plan

where her father “lights a fag in the kitchen”. “Atack” = attic

With the exception of Catriona A13’s account of the very temporal nature of her father’s smoking in the kitchen, none of the other above examples can be defined as homes where smoking only occurs outside, yet this is how they were initially described. As mentioned, differences were evident between the accounts from the advantaged and the disadvantaged areas. In the advantaged area, smoking only takes place occasionally and only when certain conditions are met, such as the absence of children in the advantaged area when children are absent. In the disadvantaged area, however, smoking which takes place in peripheral rooms on a daily basis may still not be considered smoking inside the home. Jenna D15s and James D14 drew on a hygiene discourse to explain why their parents did not smoke in the kitchen, suggesting the smell and presence of smoke would interfere with the preparation of food:

Nah, we’re not allowed smoking in the kitchen ... my mum cooks. Jenna D15s

Smoking on the threshold leading to the garden was a particularly popular practice as illustrated below by Fraser D11’s floor plan (Figure 4).



Figure 4: Fraser D11's floor plan illustrating "smoking in the doorway"

From a public health perspective, smoking in the kitchen or the kitchen doorway may be considered spatially indistinct in terms of SHS exposure. From the participants' perspectives, however, smoking on, or near, the boundaries of a home appear to equal smoking outside.

As evident from the examples above, differences, even contradictions, are evident between the answers provided to direct questions at the start of the interview process and the accounts they later provide when drawing and discussing their floor plans. As previously mentioned, most participants from the advantaged area and some in the disadvantaged area initially claimed their homes were smokefree yet, as they progressed to the floor plan task, participants would sometimes describe smoking taking place in the home at specific times and places. Furthermore, detailed accounts with anecdotes were often not divulged until drawing the floor plans. Concentrating on the details of their personal floor plans appeared to act both as a memory aide and a point to engage the participants, as I reflected in my field notes:

*The floor plans are working out really well, much better than expected really. They were meant to make the interview more fun and interactive and also to accurately separate out accounts from different participants of exactly where smoking takes place. They seem to do this **and** more. Some of the girls tonight talked about their homes being smokefree, then when they did draw the floor plans they changed their minds, saying their parents actually smoked in quite a few places. What they meant by 'smokefree' clearly differed from my definition, so really useful addition.*

I do not regard the initial statements as attempts to deliberately provide inaccurate accounts (although there is of course no way of knowing this). Rather, I would argue, any discrepancy illustrates different interpretations of what a “smokefree” home is, which the floor plans helped elucidate by encouraging their narratives to unfold and become increasingly nuanced. Participants may also have initially provided what they perceived as more morally or socially accepted accounts; this will be further discussed in the final section of this chapter. Combining these methods thereby prompted richer, more nuanced, and with some participants, rather ambivalent accounts of home smoking restrictions. Despite the value placed on the floor plans as a method of elicitation, my analysis retains a focus on the verbal accounts provided while they drew, and where they indicated smoking restrictions rather than extending the analysis to any other features of the actual floor plans. In this way, floor plans were mostly used to stimulate data rather representing data in their own right. Nevertheless, the combination of the analysis of verbal data and floor plans appeared to allow participants to disclose a wider range of accounts, which, in turn, allowed for a deeper analysis of contradictions or previously “hidden” data.

Notwithstanding the unfolding and, at times, contradictory nature of the participants’ narratives, it is important to note that even with this caveat in mind, clear differences were evident between the accounts from participants from the advantaged and the disadvantaged area. Only three out of the 27 participants in the disadvantaged area reported their homes to be smokefree, as per a “strictly no smoking indoors” definition, with two of those participants having non-resident grandparents who smoked rather than parents. In contrast, all 11 children from the advantaged area reported stricter smoking rules than those in the disadvantaged area with five participants stating that smoking never took place within the home. Minor spatial

and temporal exceptions to a smokefree home were present in the remaining six advantaged homes. These exceptions were not immediately volunteered but often revealed when producing the floor plans. For instance, when Jennifer A14 said her mother occasionally smoked in the kitchen late at night and in the kitchen doorway as previously discussed, or when Jack A11 and Michael A12 spoke about their fathers' smoking in the utility room and the study respectively.

Michael A12: My Dad just smokes whenever, but he doesn't smoke a lot but if he does smoke he might smoke in his car or he would just smoke outside ... sometimes he smokes in like his [home] office or something, not really in the house a lot ...

NRD: Do you ever stand or sit next to your Dad when he smokes?

Michael A12: Well, sometimes but not often. When I'm doing my homework or something in his office.

NRD: And what's that like?

Michael A12: Well, it's ... but when I am talking to him he tries to hold the cigarette away so it's not really that bad.

The way Michael A12 frames his father's smoking practices, framing them with "might", "sometimes" and "just" are attempts to add up to his final statement here: his father's smoking indoors is "really not that bad". Again, Michael A12 constructs his father's study as not being "in" the house. It is his father's space within which Michael A12 rarely spends time, the exception being when using the computer to do his homework, so a peripheral and adult space within a largely smokefree home. Adding that his father "*tries to hold the cigarette away*", he says his father is taking precautions to protect him and by stating "*so it's not really that bad*", so negating any presumed moral judgment of a parent smoking near children casting doubt on their moral character or protective parental role. Like utility rooms, dining rooms and playrooms, studies illustrate the spatial differences between the homes of participants living in the advantaged and the disadvantaged areas, as shown by Jennifer A14's floor plan of the ground floor in her house (Figure 5).

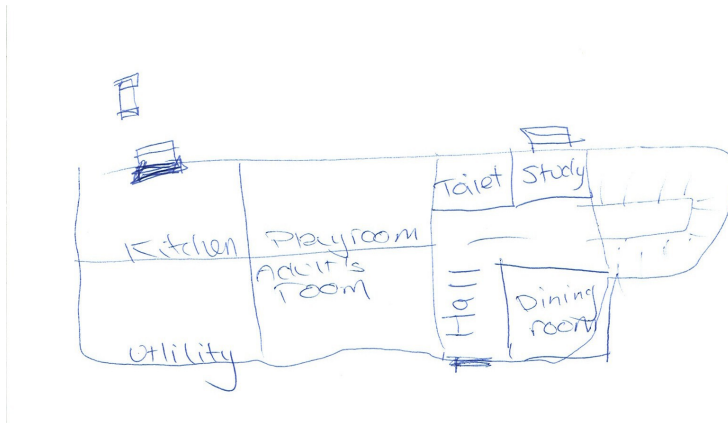


Figure 5: Jennifer A14's floor plan of the ground floor in her home

The ground floor of Jennifer A14's home has a utility room, study and dining room as well as two sitting rooms, one for adults only and one for children (the playroom). Within the disadvantaged area, homes seldom contained more than three bedrooms, one bathroom, a sitting room and a kitchen. Following an interview with Lauren A13 and Jessica A12, I remark on the stark differences in the indoor space available between participants from different areas in my field notes:

While the boys and girls I interviewed last week in [disadvantaged area] did the floor plans quickly, these girls actually struggled to remember all the rooms in their houses. Jessica A12 had two sitting-rooms, one for her parents and one for the children, and while her older brother smoked in his room she was not exposed to his smoke as that was the converted attic space that ran across the whole of the house.

Participants from the advantaged area did not share bedrooms, but around half from the disadvantaged area either shared their bedroom with a sibling or said that their siblings shared with each other. The disadvantaged homes often contained three bedrooms, a kitchen, a bathroom and a sitting room, with one of the bedrooms often shared between siblings (see Figure 6 below). The two exceptions to this rule had two and four bedrooms respectively, with the latter housing a family of seven.



Figure 6: A house with three bedrooms (one shared) in the disadvantaged area

Overall, participants from the disadvantaged area reported less smoking restrictions. Indeed, four participants from the disadvantaged area claimed their homes had no smoking restrictions at all and those participants expressed no concern about this. Furthermore, as discussed in Chapter 5 in the context of how group dynamics can affect accounts of SHS and risk, Mark D13s said his family all enjoyed the smell of smoke and had no restrictions.

6.3. Protecting the vulnerable

Where smoking in the kitchen or kitchen doorway did not always signify “smoking in the home” to children, smoking in the sitting room appeared to tip the balance to clearly indicate a home where smoking was permitted (if restricted in other ways). Reportedly permitted in 21 out of 27 sitting rooms in the disadvantaged area, smoking was not permitted in any sitting rooms of the advantaged homes. While permitted in many disadvantaged sitting rooms, smoking practices were subject to some adjustments. In the disadvantaged area, smoking in the sitting room was

subject to one clear restriction associated with the presence of very young or asthmatic children. In Chapter 5, I discussed how these groups were considered particularly vulnerable to SHS exposure, and temporal restrictions such as these appeared informed by this understanding. Refraining from smoking next to a baby or, for many, a toddler, represented a baseline in smoking restrictions, common to both areas and emphasised in the following extracts from three interviews and focus groups:

Well, sometimes they like go out [of the sitting-room] the back green or just into the kitchen [...] like if my wee brother's [age 2] there. Ryan D14

They smoke in the living room most of the time but if my wee brother [aged 3] is sitting next to them they don't. Rebecca D14

Young or asthmatic children were most frequently mentioned in this context but pregnant women represented another group that warranted protection from SHS.

Alexa D10: My Dad never smokes when there's a baby in the house, he goes outside the house.

Leah D10: My dad smokes in a completely different room from everyone else.

NRD: Ok, why do you think that is?

Leah D10: 'Cause they don't want everyone else like wee [niece, aged 6 months] breathing in the smoke.

Alexa D10: My uncle goes in a different room and my dad goes outside.

NRD: And why do you think he goes outside?

Alexa D10: To keep it away from me and my mum's pregnant.

Note the way in which Leah D10 and Alexa D10 emphasise the non-negotiable and clear rule protecting those considered vulnerable constituted for their fathers by saying they “never” smoke in the proximity of a baby and smokes in a “completely” different room. Participants clearly differentiate between the impact of smoke on younger and older children, however. It is not always clear whether some

participants defined babies as children at pre-walking stage, toddlers, or, as in two of the quotes above illustrate, children under the age of five.

Yet most participants reacted strongly, expressing surprise and horror, at the mother in the picture holding such a small baby while smoking. Danielle D15 and Rachel D13s discuss this in the following excerpt, while also laughing at their exaggeration of SHS discourses (as discussed in section in Chapter 5):

Danielle D15: And that's minging 'cause they're smoking beside a baby. Or a cat. And it could die of passive smoking. [laughter]

Rachel D13s: And the baby only looks a couple of weeks old! [high-pitched at the end] [laughter]

When such measures were elaborated on, their temporary nature is clear in some accounts from participants in the disadvantaged area. In contrast to parents in the advantaged area who leave when they smoke, Ryan D14 describes how his father protects him from SHS by asking him to leave the room when he lights a cigarette and ask him to return when he has put it out.

Like, I'll be sitting next to him and I know he's gonnae smoke a fag 'cause he takes it oot his pocket or something ... and he's always got an ashtray next to him ... and as soon as he blows it oot I go to the next room and when he's finished he gives me a shout ... 'cause I've had like quite a lot of problem with my asthma like, well smoke and that and when I run and that ... I've always got a problem with my chest and that.

Robbie D10 also described being ordered to leave the room temporarily when his parents smoked:

Robbie D10: Mum and dad smoke in the living room. Sometimes.

NRD: Sometimes? Does it depend on anything?

Robbie D10: they don't really smoke when I'm there.

NRD: They don't smoke when you're there. Can you tell me a little bit more about that? How does that happen?

Robbie D10: [They say] 'Go up to play.'

Older children were therefore also protected in some cases. As shown in Rebecca D14's account, however, many parents' protective measures differ for younger and older children, with the latter being significantly less stringent.

When my wee brother's [aged 3] in the kitchen they go in the back green and then like when he's upstairs they just open the window, you know.

Requesting that the children move away but still remain in the same room appeared an acceptable and protective practice to participants who described it. Julia D11 discussed this latter situation, while discussing her and Amber D10's floor plans:

We sit here (indicating once side of the room) and they sit there (indicating the other side) and the telly is there (indicating the middle) and he always sits in here on this chair so when he smokes he's like 'go over there' or 'go to the kitchen with your mum.'

Prior to drawing and pointing at their floor plan, I had assumed from their statement that their stepfather "smoked away from us" meant smoking outside or in a different room rather than in the same room but further away. This is another example which illustrates the strength of the interview/floor plan combination in gathering nuanced and perhaps more accurate data. Most participants are quick to describe these protective strategies. One purpose of such strategies becomes clear in a focus group where Danielle D15 challenged Rachel D13s's account of her mother protecting her from SHS:

Rachel D13s: Mum doesn't like me sitting on the couch when she is smoking, because she always goes if mum and dad are having a fag she goes 'Go away.'

Danielle D15: I've seen your mum next to you with fags before [smiling].

Rachel D13s: Aye but...you know what I mean [annoyed] [staring daggers at Danielle D15 for quite some time after this exchange].

Again, Rachel D13s uses the word "always" to emphasise this is not something that changes at certain times. By challenging Rachel D13s's account of her mother's

protective practices, Danielle D15 appeared to question not just the validity of Rachel D13s's account but perhaps also her mother's moral identity as a parent who should protect her children. Up until then, the dynamic between them had been characterised by good-natured banter and teasing. This challenge of the validity of Rachel D13s's account and her mother's protective smoking practices resulted in a more subdued and less boisterous interaction between them. It was as if Danielle D15 had unwittingly broken a social rule and overstepped the boundaries by implicitly suggesting Rachel D13s's mother did not protect her in the manner she had described. Evidently, smoking practices around children implies caring and moral entities in parents and others. Suggesting that her mother did not protect her in the way she described appeared to be experienced as a threat not just to the validity of Rachel D13s's account but also to her mother's moral identity.

As described previously in relation to SHS risk, accounts given by participants who smoked about family smoking practices differed from those who did not. Rather than emphasising their parents' protective measures, four out of these six participants' accounts amounted to a literal or metaphorical shrug of the shoulders with these participants stating how irrational protecting them from SHS would be when they smoked anyway.

Thomas D15s: I don't think my Mum bothers 'cause she knows I smoke anyway.

NRD: So she just thinks well you're smoking so...

Thomas D15s... so we're going to be sitting in the same haar.

While the younger three participants who smoked said they smoked without their parents' knowledge, smoking was described as a joint or accepted activity by the older three. They spoke of parents giving them cigarettes and smoking with them in their homes. Jenna D15s said she not only smoked with her mother when her father was not present, indicating her mother had accepted her smoking:

Yeah, I always smoke in front of my mum if I'm in the house and my dad isn't there [...] ...like my mum's alright.

Jenna D15s also said that she had tried to quit with her mother but they had both resumed within a day or two.

In the disadvantaged community, participants mentioned several occasions when smoking restrictions would be eased. Social occasions with guests and alcohol often lead to a temporary lapse in smoking restrictions in participants' accounts, or even in failed quit attempts, with boxing matches and football games mentioned as times were parents and their friends would drink and smoke more than usual. Victoria D12's floor plan, (Figure 7) is the only one that illustrates the easing of restrictions, however.

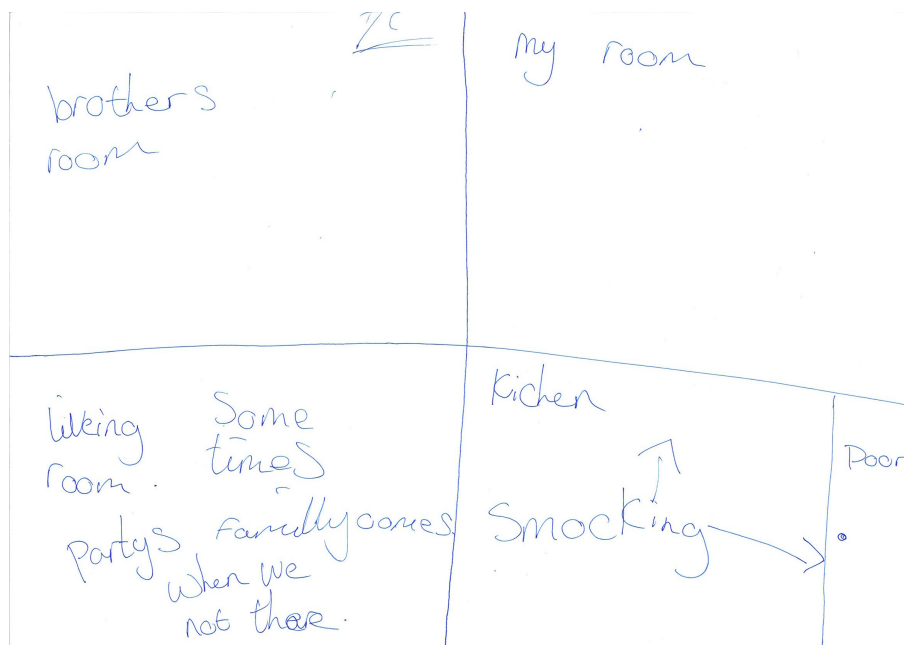


Figure 7: Victoria D12's floor plan illustrating temporal easing of restrictions "living room [smoking] sometimes when family comes, parties, when we are not there."

Jenna D15s: from what I can remember ... I remember my dad's pal smoking in the kitchen.

NRD: OK, what happened then? Did anyone mind or?

Jenna D15s: My mum didnae mind 'cause it was like a party. Other than that there's nae smoking in the kitchen.

NRD: ...so have your parents always gone into the kitchen, when you were

wee or...

Rebecca D14: Aye, but sometimes like if they were having a drink and with their pals in the living room then they would smoke there with the drink and their pals ... then they usually have a fag in there and the living room door is kept open and it all just gone away and through the window as well ...

As evident in this extract, such lapses did not appear to be considered particularly seriously by participants. Normal smoking restrictions could also be lifted in the disadvantaged community due to adverse weather conditions, when smoking outside or with windows and doors open would be too unpleasant. Ryan D14 also talked about different smoking restrictions applying to different people but with more stringent restrictions applying to guests.

Ryan D14: No, I would always like shut my bedroom door. It's just my dad who really smokes inside 'cause he's like ...proper family. Like blood family. And if all my uncles smoke they've just got to stay oot and my Dad will just have a fag like.

NRD: What about when you're there?

Ryan D14: My mum kens I've got asthma so she'll stop, them naebody smokes in the same room.

Participants from the disadvantaged community were the only ones who mentioned temporary easing of restrictions relating to visitors and the weather. However, as with Ryan D14's mother, Anna A12's mother was also reported to insist on outdoor smoking because of her little sister's asthma:

Well my uncle he comes over quite a lot and [...] my mum makes him go outside [to smoke] 'cause it's really bad for my sister's asthma.

There is a suggestion of a gender discourse in Ryan D14's account. While Ryan D14 reports his mother enforced smoking restrictions to protect her son with asthma when they had visitors, a different rule applied to his father. Jenna D15s describes her mother's strict enforcement of a no smoking rule in their car but this does not include Jenna D15s's father:

No one's allowed to smoke in our car, well my mum's car, my dad smokes in my mum's car.

Gender may therefore be a factor in where parents' smoking occurs in the home and who sets the rules. While Ryan D14 and Jenna D15s's mothers are reported as setting and enforcing smoking restrictions within their homes, their fathers are reported to be subverting the rules without hiding, or consequences, possibly illustrating that they are the ones with the real power. Mothers are reported to set and enforce the restrictions with reference to traditional female role in the family as those caring for child health, particularly when compromised by asthma, and cleanliness in the kitchen and their own car space like Jenna D15s's mother. Two mothers smoked in the advantaged area. Anna A12's stepmother was reported to only smoke on the balcony and Jennifer A 14's mother was reportedly forced to smoke outside by her husband and children and only smoked inside (perhaps without the father's knowledge) late at night after a night out. Lindsay D11 also talked about her mother walking away to smoke as a way of diffusing fractious domestic situations related to childcare.

Lindsay D11: my mum goes into the kitchen and shuts the door behind her.

NRD: And does she talk about why she does that?

Lindsay D11: She says that she's really stressed 'cause she has to shout at me and my brother.

Bedrooms constitute the clearest example of where smoking restrictions are rarely if ever eased and thus illustrate social norms regarding smoking restrictions. While seven sets of parents were reported to smoke in their own bedrooms, children's bedrooms were always subject to strict smoking restrictions and almost never ticked on home floor plans. This appeared to be an extension and strengthening of the temporal smoking rule never to smoke in the same room as a toddler previously discussed. Reasons for such restrictions appeared to be so self-evident that participants never explained it, just looked stunned when I would ask, thus illustrating a case where what is unsaid can show social norms more clearly than any words would. Reasons for parents not smoking in bedrooms were usually that

sleeping in smoke was considered unpleasant, and sometimes as posing a risk:

Jenna D15s: Aye...my mum hates people smoking upstairs.

NRD: Why?

Jenna D15s: 'Cause of seeing fires and ... like my mum goes to bed and she doesn't smoke until she wakes up.

Parents and other adults refrained from smoking in children's bedrooms, mostly the reason given was to protect children, but Amber D10 gave a different reason which points to the realities of growing up in disadvantaged circumstances.

NRD: Does [your stepfather] ever smoke in your room?

Amber D10: No, not really 'cause it's too cold 'cause that's not where the boiler is and it's not got a telly or anything, it's not as warm as downstairs, it'd be quite silly if you were freezing cold and you were in the bedroom with nothing to do and open the window that would just make you 10 times more cold.

The only reported incidences of smoking in children's bedrooms was when participants themselves smoked in their own bedrooms, often without permission from their parents.

Lewis D13s: Yeah well, everyone smokes in my family like, but my mum and everyone smokes in a different room and the people who dinnae smoke are in a different room.

NRD: OK, what room are the smokers in?

Lewis D13s: My sister's room. A bedroom. The rest just sit and watch telly.

Three participants in the disadvantaged area who had few or no smoking restrictions ticked bathrooms as rooms where smoking took place. Other than that, the only mention of smoking in bathrooms was Jack A11 talking about how his father used to smoke there but how he and his mother fitted a smoke alarm in there forcing him to smoke in the utility room, a more peripheral room where other people spent less time, particularly guests. This will be further discussed in relation to children's

resistant strategies in Chapter 7.

6.4. Smoking outside

Two participants lived in flats without private outdoor space but these were the only two participants who reported their parents and grandparents only ever smoked outside. Taylor D14 lived with her mother who smoked outside and Fraser D11's parents' did not smoke, but his grandparents, who smoked everywhere in their own home, always went downstairs and outside to smoke when visiting him.

As mentioned, initially many participants would state their parents and other family members always smoked outside. Smoking outside or smoking in a peripheral indoor space with windows and doors open were sometimes synonymous in accounts, however.

In the advantaged area, several parents and others smoked outside. For Anna A12, smoking in the front garden was an issue because of its visibility and I will return to her account later in this chapter.

For most other participants, smoking in the garden was said to be the right and considerate thing to do, and for Jennifer A14, there was even a silver lining to her mother smoking.

Jennifer A14: Yeah quite a lot it's the only time I really get to talk to her without some kid screaming for her attention ... 'cause she doesn't let [sister] come and sit next to her as she's so little so it's really nice to get to talk to her on my own. If she quit I don't know if we would get her and me time like that. I still want her to though, but that's like...

NRD: A silver lining?

Jennifer A14: [laughter] Yeah, it's nice when we're on our own and she seems calmer you know?

6.5. Smoking in cars

Accounts of smoking in cars contrast with those on smoking in the home in two

significant ways. Firstly, while views diverged about smoking in the home to some extent, nearly all participants were vocal about disliking smoking in the car, including three of the participants who smoked (the remaining three did not have family cars). The more concentrated levels of smoke in the car with no means of escape to a less smoky space, led to a feeling of being trapped, which led to arguments between children and parents. Secondly, and in contrast to the home data, no area differences in smoking practices were evident. Illustrating both these strands in the data, Jenna D15s, who sometimes smokes with her mother in the sitting room of their home, gives a very different account of her mother's dislike of smoking in the car and the stricter rules which apply there.

Jenna D15s: 'Cause when we're like in my cousin's car, she smokes while she's driving, she smokes quite heavily when she's driving but my mum never smokes when she's driving and then if someone smokes while she's driving the car she's like [puts on angry voice], 'Roll that window down.'

NRD: [laughter] And what do you think about it?

Jenna D15s: I dinnae like smoking in the car, it's too claustrophobic.

NRD: Right, OK, and what do you do if someone is smoking in the car?

Jenna D15s: I always sit by the window anyway.

NRD: Do you, even when it's winter, you'd roll the window down? Do they not complain they're cold?

Jenna D15s: Yeah but I say, 'Dinnae smoke then.' [laughter]

Socioeconomic status largely stratified accounts of home smoking restrictions, yet such stratification was not apparent in accounts of smoking restrictions in cars. In the disadvantaged area, six participants did not have family cars and seven participants said they had smokefree cars. In the advantaged area, all participants but one had close family members who occasionally smoked in cars.

Nah [they don't smoke in the car]. In the last car but my mum and dad have a new car and my dad's ash came back and it fell on the floor and it went on the carpet and ... my mum and dad have a fag and we sit behind them

with the windows open and it blows back in my face and I didn't like that so that's, they don't smoke in the car plus I have a younger brother (aged 3). Rebecca D14

Some of the parent who used to smoke in their cars no longer did so according to some participants.

NRD: Are you ever in a car with anyone who smokes?

Meghan D10/ Nicole D11/ Isla D12: They'll stop at garages and smoke. Or they open the window ... and then no one wants to sit near that window 'cause they get cold.

Unlike smoking restrictions in the home, most of the parents in the advantaged area smoked in the car although temporal restrictions were sometimes in place during shorter journeys. The stress of driving in traffic was one of the reasons provided for smoking in the car.

Never elsewhere [in the house] but in the car when she gets stressed by traffic she lights up... and I roll all, I roll the windows down and lean forward and cough and then she gets cold and angry and shouts [laughter] but I don't care, it's such an enclosed space I can't breathe, otherwise. Jennifer A14

In fact, when Jennifer A14, drew her floor plan she indicated her mother smoked in the kitchen sometimes late at night, but smoking in the car appeared to be a daily occurrence. Others stated their parents would smoke on long journeys:

Horrible when [the smoke gets] in your face. Dad doesn't normally [smoke in the car], more like on long journeys. Chloe A11

Consequently, smoking in the car was as, or indeed *more*, contested as smoking in the home and participants were less tolerant of it. The lingering smell, and, at times, the mess of ash on the car floor, what is more, they would pull faces and make choking noises. This distaste was due to the smaller space, the inability to walk away and the way in which ways of managing the smoke in the home, such as opening the window, had the opposite effect in the car, leaving participants with very limited ways of avoiding it:

Smoking in the car [is] probably [worse than in the house] because even if you have the windows open it won't go out ... also, 'cause if like... the smoke automatically goes back rather than forward so you get smoke in your face ... so that's why I sit on the opposite side from my Dad when he smokes. Jack A11

Worse if you sit behind the driver and he opens the window and it all blows back to you. Catherine A13

6.6. Restrictions and responsibility

Participants' descriptions of home and car smoking practices position families in a certain manner, a manner which implies that they have a clear moral stake in the way they present their parents' smoking practices. Many participants relied on a particular repertoire which, explicitly or implicitly, served to distinguish their practices from the less controlled and irresponsible practices of others. Such a distinction was often immediately apparent in the reactions to the picture of smoking in the home stimulus material I made use of (see Chapters 4 and 5).

My intention to depict smoking in the home in a relatively neutral manner (without reference to socioeconomic status or a specific age of children, for example) was somewhat thwarted by participants' immediate castigation of the adults smoking in the prompt picture as "*irresponsible*" and "*minging*". When elaborating, these derogatory terms were specifically about smoking practices rather than smoking status, however, as they based it on the perceived failure of the parents to take measures to protect the baby and (albeit to a lesser extent) the older children in the room. As is evident below, the small baby is sitting in the "father's" lap and the window is shut which led participants to state "*He has a baby in his lap!*" and "*That's so unfair*".

The picture, and/or the topic of the study, also appeared to prompt opening statements by children relating to the danger of smoking and the importance of responsibility for children, such as this one by Amy D11 (also discussed in Chapter 4):

You especially don't want to smoke when you're pregnant 'cause all the

smoke will damage your lungs and affect the baby and the baby can die in your tummy, or when it comes out and it's a bit older, it will smoke and it could die of smoking.

In these statements, children often equated smoking with irresponsible parenthood saying what they were witnessing was “unsafe” and “irresponsible”. As this chapter has illustrated, when children talked about smoking within their own families and homes, more nuanced accounts of parents’ and siblings smoking practices are forthcoming. Several participants also pointed out that their mothers did not smoke when, or because, they were pregnant, carefully both distinguishing their practices from others and establishing their moral identity as not smoking when it could harm small children.

The many ways in which the smoking practices in the prompt picture were said to be irresponsible were present in nearly all accounts but those of some very quiet participants or some of those who smoked themselves, but participants from different areas referred to different strands of it. In the advantaged area, they disapproved of smoking indoors generally and in the presence of children specifically. Some of these participants also referred to the older children in the stimulus picture. For example, Jack A11 pointed at the older children stating “*they look angry*” and Chloe A11 said “*it must be horrible to be in that room but they [older children] wouldn't like to say in case the parents got angry*”. Notably, participants in the disadvantaged area did not mention the older children but made different distinctions. Rather than saying smoking in the presence of children was irresponsible, most would point out that the “parents” smoked in the presence of a *baby* with apparent disregard for any health impacts or any efforts to protect him or her. Julia D12 estimated the age of the baby as “*not more than 5-6 weeks old*”, thus drawing attention to the baby being particularly young and vulnerable. And, rather than necessarily emphasising that they smoked indoors like participants from the advantaged area did, participants from the disadvantaged area would instead point out that “*they've got the window shut*”.

In this way, participants put their close family members’ smoking practices in a favourable light by comparing their practices to those of the generalised “parents” in

the drawing. These parents are a point of comparison, a conversational tool and they compare unfavourably to close family members. These other less responsible people can also be more distant member of their family, friends or neighbours, as in examples given by Jenna D15s, who makes an explicitly unfavourable comparison between her cousin's "disgusting" smoking practices and her mother never allowing smoking in the car. Mostly, what is considered "bad" is implicit in the juxtaposition between their close family members' responsible smoking practices and the less responsible practices of others. For example, Rebecca D14's first talks about her parents never smoking when her little brother is around and then gives the following account of her grandmother's (chain) smoking practices:

I hate going to my nana's 'cause my nana's a bad ... a heavy smoker and she like starts off a fag, puts it doon, blah, blah, blah, starts off a new one again and I'm like, 'Nan I can't breathe,' and she's like [puts on a high-pitched voice], 'I finished one about 20 minutes ago.' [laughter].

Smoking "everywhere", "a lot" and in the presence of babies and small children are thus considered "bad" smoking practices. Unlike these unregulated and irresponsible practices of other smokers, close family members were most often described as responsible by avoiding smoking in the presence of children and as regulating their smoking by not smoking much and only in particular places. Drawing my and the other participants' attention to the failures of the parents in the image and contrasting them to their own family members practices serves to position the latter in a favourable moral light. They might smoke, but unlike the parents in the picture they smoked in a responsible manner by protecting children. Most participants took the opportunity to highlight the differences between the image and their family's smoking practices, but the measures they were describing differed between families, as will be discussed later in this section. A "bottom line" of never smoking around babies is detectable in most participants' accounts, however, and participants would be careful to establish that early on in my interaction with them.

Most of the children I interviewed spoke about SHS and their families with relative ease, yet others proved more reluctant to share their views. A few participants contributed very little which can, of course, be interpreted in many ways: they may

have had little interest in the topic, they may have been uncomfortable in a group situation, in that particular group, or indeed, with me. Their hesitance may also be due to wider stigmatising societal discourses on smoking within the home and parental smoking in particular. Participants from the advantaged area were not as forthcoming about wanting to participate in the research. When first involved, they were usually more hesitant, and pauses, silences and embarrassed giggles characterised much early discussion in these groups. It was as if talking about parental smoking practices was embarrassing.

In addition to responsibility, a related but separate theme of self-regulation is also interwoven in accounts. Family members are both positioned as smoking few cigarettes and in few places, hence regulating their smoking in a controlled and responsible manner. A few participants talk about their parents not smoking as much as others, for example Robbie D10 saying his parents will be “*lucky if they smoke 10*”. Not smoking much signified not being addicted to Alexa D10 who asserted, “*My Dad’s not addicted*”, because being addicted was about smoking a lot.

In the advantaged area, in particular, tales of showing one’s distaste of smoking and arguably, smokers, were evident. Anna A12, whose uncle and stepmother smoked, expressed particularly strong views on SHS and smoking. She robustly opposed her uncle’s and stepmother’s smoking per se and also talked about forbidding her uncle to smoke in her front garden because of the detrimental impact this could have on her and her family’s reputation in an area where smoking was not an acceptable behaviour.

Addiction was used as an explanatory concept as to why their family members smoked by some, while others talked about the stress their family members experienced, either as a reason to smoke, or as a reason not to stop smoking. Lewis D13s talked about his own smoking in this context. Explaining he had a signed smoking permission from his mother for his residential unit, he smoked in his bedroom in that unit despite this not being permitted.

Aye, I smoke my fags [in my bedroom] but if they caught me they’d

withdraw my smoking permission, not that my ma would let them.

Accordingly, he alludes to his mother protecting him from stress by letting him smoke. More frequent than statements pertaining to the amount of cigarettes family members smoked, however, were statements of them imposing stricter smoking restrictions than others. Such restrictions were imposed either by the smoking parent(s) themselves, or in a few cases, the non-smoking parent together with the children. The implementation of smoking restrictions are frequently a distinguishing feature in accounts of family members who smoke and one that contrasts to those who smoke “everywhere”. However, acceptable/desirable smoking practices change between areas, for example, those pertaining to indoor and outdoor smoking. With some temporal exceptions, participants mention parents only ever smoking outside in the advantaged area. Such exceptions would be strictly childfree areas due to either the space and/or the time of day.

In the disadvantaged area, most participants also used smoking restrictions to distinguish their close family members from other people who smoke, which, by implication, lacked similar control. However, here, the presence of smoking restrictions *per se* appears adequate to distinguish “good” smokers from “bad”. Marked differences between communities in the moral connotations with regard to smoking itself as well as indoor smoking restrictions are evident. For example, while some smoking restrictions in the home are considered “good” in the disadvantaged area, only an indoor smoking ban is acceptable in the advantaged area.

Accounts of their parents’ smoking practices appeared to serve the purpose of establishing and defending their parents’ moral identities and may highlight prevalent moral assumptions surrounding smoking. The moral imperative of parenting is caring for children and putting their needs first. If parents smoke, their moral identity appeared to be potentially under threat, judging by the many justifications put forward by their children.

The following is an extract from an individual interview with Ryan D14, who describes how his father protects small children from his smoke and has tried to quit

to protect his children.

NRD: OK. So what about when you're in a room, say you're sitting in the living-room and your mum and dad come in, do they sit and smoke with you or ...

Ryan D14: Well, sometimes they like go out the back green or just into the kitchen.

NRD: OK, and what do you think that depends on?

Ryan D14: like if my wee brother's there.

NRD: ...when your parents smoke, have you ever asked them to stop?

Ryan D14: Yeah... 'cause my Dad's tried before and he says it's hard ... not that long ago he seriously tried to stop.

NRD: OK, did he say why he tried to stop?

Ryan D14: For us, me and my wee brother

NRD: What did you think about that?

Ryan D14: He was that proud of himself but then he couldnae.

Using these examples, it is possible to outline the steps children take in presenting their parents as moral, good, thoughtful and caring. Unlike other smokers, they do not smoke a lot, have attempted to stop and restrict smoking to protect others particularly children.

Participants did not necessarily tell the same moral tales in terms of the details, however. Importantly, spatial and temporal smoking restrictions within the home were significantly stricter in the advantaged community. Participants from the disadvantaged community would talk about their parents protecting them from SHS by keeping a few rooms smoke free such as children's bedrooms, sometimes the kitchen and/or the living-room or by asking the children to temporarily leave the room, or that *part* of the room, when they smoked.

Julia D12: My mum and dad smoke inside but they make sure we're away [pointing to one side of living room] ...

NRD: So you're saying they smoke a bit away in the room or?

Julia D12/Amber D10: Yeah, uh huh.

Julia D12: We sit here (indicating one side of the room) and they sit there (indicating the other side) and the telly is there (indicating the middle) and he always sits in here on this chair so when he smokes he's like, 'Go over there,' or 'Go to the kitchen with your mum.'

Jenna D15s: When my wee brother's in the kitchen they go in the back green and then like when he's upstairs they just open the window, you know.

Similarly, while smoking reportedly took place in approximately half of the cars in both areas parents were still presented as taking some precautions and being considerate of others:

Julia D11: My dad smokes in the car but he rolls down the window and he like, even if it's raining sometimes, even if it's like really heavy rain he doesn't open it and he doesn't smoke but once it's like sunny or when it stops and he smokes.

Clearly sensitive to the moral judgements that may ensue, Catriona A13 explicitly referred to it:

*Well, I ... I don't mind my Dad smoking even though I don't like it but...[...] I don't think people should be like **judged** because they smoke.*

Thus, while their parents and other family members may be putting their own health at risk, they are reported to show consideration for others in terms of where and with whom they smoke. Responsible smoking practices – by extension – appear to say something important about their family members' moral value, according to participants.

Examples of bad smoking practices are used as a point of downward comparison to “responsible” practices where people control the amount of cigarettes they smoke, restrict the places they smoke in and, crucially, never ever smokes in the presence of

babies and small children. Invariably, “good” smokers are participants’ family members. In this way, many participants construct accounts that purposively distinguish their family members as hygienic (avoiding the smell of smoke all round the house and car), considerate of others and with a measure of self-control. As this chapter has shown, a few do not engage with this discourse and express indifference or anger at their parents.

6.7 Conclusions

In this chapter, I have offered an analysis of participants’ accounts of where and when smoking takes place in their homes, mainly derived from their explanation of their home floor plans. Rather than accounts *of* parental smoking practices, many of these accounts amount to children accounting *for* their practices. Using other less responsible “risky” practices as a discursive device, most participants defended their parents and other close family members’ practices by detailing how they manage the risks in comparison to those who do not. Instead of smoking everywhere at all times like some others, they managed, controlled and limited their smoking to times and places more appropriate in a rational manner, exemplifying the rational risk avoider (Tulloch and Lupton, 2003), resisting the idea of the smoking parent as a risk-taker. In this way, participants can be said to have created “negative communities of interest” (Douglas, 1992) of other people who smoked rather than of expert scientific SHS risk discourses like mothers who smoke have been found to do (Robinson x).

In other ways, however, the data closely resemble the shape of moral accounts in line with mothers’ accounts for their own smoking (Coxhead and Rhodes, 2006, Holdsworth and Robinson, 2008). Simplistically, people who smoke in the following way are characterised as “good” if they control and restrict their smoking in various ways to protect others and their homes from the dirt and risk SHS entails, in contrast to those who do not. In this way, participants construct accounts of their parents as responsible risk managers to resist any notion of an irresponsible risk-taking discourse. Alternative or complementary discourses of addiction and difficult life circumstances are also drawn on to exonerate parents from individual responsibility for smoking practices.

As in chapter 5, I have attended to the ambivalent nature of some accounts. Specifically, some accounts of where and when their parents smoked within the interview or focus group appeared to contradict later accounts given in the floor plan task. Rather than casting doubt on the validity of participants' accounts (see Chapter 3), I would argue this illustrates both the importance of methods, peer context and participants' definitions of smokefree homes. Methodologically, a combination of verbal accounts and floor plans was particularly useful in examining children's definitions of homes which are smokefree and homes where smoking is permitted but restricted: illuminating the way in which some participants defined smokefree differently from the standard definition. Furthermore, floor plans appeared to act as a memory aid, prompting detailed and more concrete accounts of restrictions while reminding participants of personal anecdotes that may otherwise have been lost in the context of the briefer, less detailed and abstract accounts they tended to give in an interview context. The floor plans have also highlighted that there are other spatial and environmental barriers than those of lack of garden space and supervision of small children mentioned in previous studies (see chapter 2 for a review). Participants in the advantaged community live in more spacious homes which allows a clear separation of people who smoke and those who do not inside the house.

Additionally, participants' definitions of "smokefree" do not always entail a home free from smoke. Definitions of a smokefree home appear to range from one where smoking does not take place, to one where smoking takes place only in certain areas, such as the kitchen or hallway. These discrepancies highlight the risk of misconstruing children's responses about smoking when we are not sensitive to the ways in which such responses are informed by their (developing) understandings of smoking practices and the context of their narratives (Mair et al, 2006). It is not that children deliberately provide "false" or inconsistent reports, but that we may need to delve a little deeper to understand what they mean by smoking being allowed or not within the home and car.

Restrictions may also apply to some people but not others, such as fathers, illustrating the importance of gender. Gender has represented an important analytic factor in previous research about interactions in the home around smoking practices

(for example Greaves, 2007, Robinson et al, 2012). While not a strong theme in my research, it appears the data presented here support previous findings about fathers' and male partners' power to either decide or ignore smoking restrictions that apply to others, a finding interesting to pursue in future research (see Chapter 8).

Access, or the lack thereof, to an outdoor space is often cited in previous research as a key barrier or enabling factor to smokefree homes (Jones, 2011). Yet, as only two participants lived in flats without gardens, and those homes were smokefree, this is not reflected in my data.

More children disliked and claimed to be physically affected by smoking in the car. The experience of being trapped with no escape from direct exposure and the increased concentration of smoke is said to be much worse compared to smoking in the home where separation from people who smoke, however temporary, is possible (and often encouraged). The car thus appears to represent a qualitatively different experience of being exposed to SHS than home smoking does and one that children particularly object to. In the home, opening windows has the immediate effect of dispersing visible smoke, whereas in a car, that tactic has the opposite effect of concentrating the smoke at the back of the car where children tend to sit. Unlike the home there are no boundary or marginal spaces where smoking can occur.

When smoking takes place within the home as it does in the majority of participants' homes in the disadvantaged area, it is in family spaces such as sitting rooms and/or kitchens with only the children's bedrooms being out of bounds in most homes. In contrast, adults in the advantaged area who wanted to smoke indoors had utility rooms, studies and master bedroom balconies at their disposal: domestic spaces which did not feature in the accounts or floor plans of participants from the disadvantaged area. Nearly all parents are said to take measures to protect their children, yet smoking in the home still appears to be primarily on adult, particularly parents', terms. In the next chapter, accounts of child agency and the ways in which it is constrained, will be further explored.

Chapter 7: Practices of resistance

7.1. Introduction

This chapter examines participants' perspectives of the interaction and negotiation between themselves and the adults who smoke in their families in relation to smoking practices in the home and car. As evident in Chapter 2, previous literature has largely focused on the vulnerability of children exposed to smoking in the home and car and thereby implicitly positioned children as passive, voiceless and with little, if any, role in negotiations around smoking restrictions. In contrast, this study is informed by Childhood Studies, which positions children as actively shaping their social worlds. This chapter takes the active roles as its point of departure, yet does not deny the constraints on child agency. The various strategies, or "practices of resistance", that participants use when attempting to negotiate their family members' smoking will therefore be discussed within a framework which recognises what can suppress and enable such actions and the accounts of them.

This chapter outlines accounts of strategies to obstruct smoking and discusses the purposes and effects such strategies may have. While overt and covert strategies sometimes overlap in participants' accounts of family interactions, there is a suggestion of a trajectory of resistant strategies over time in some accounts. Some participants say they started by overtly opposing family members' smoking by asking their parents to stop smoking, for example, and then proceed to other more covert strategies when unsuccessful, such as hiding cigarettes, and then finally ceased to protest. The structure of this chapter follows this trajectory, beginning with accounts of overt challenges to family smoking, continuing with a discussion of more covert challenges, and finally, by examining the absence of resistance in some accounts.

7.2 Overt practices of resistance

Overt practices of resistance refer to accounts of actions that directly and openly

challenge family members' smoking. These include asking family members to stop smoking, drawing attention to the unpleasant smell and taste of SHS by exaggerated coughing, wrinkling of the nose and turning away with the expressed intention of making the person who smokes feel "embarrassed", "bad" and/or "guilty". Overt practices were referred to more frequently than, but not always to the exclusion of, covert practices. Of the 20 children who talked about attempts to obstruct smoking overtly, seven also talked about engaging in covert strategies.

Direct requests to stop smoking, or less frequently, to stop smoking in the participants' presence, were described as protests borne out of frustration, evidenced by the tone of voice used when recounting interactions:

NRD: Have you ever asked your mum and dad not to smoke?

*Robbie D10: I've **told** them. [annoyed voice]*

NRD: [laughter] How have you told them? Tell me what you said?

Robbie D10: 'Why do you have to smoke?' [angry voice]

Most participants who reported they had asked their parents to stop smoking had done so once or twice, or on a handful of occasions at most. In contrast to such accounts, Ryan D14, Jack A11, Jennifer A14 and Danielle D15 described particularly persistent attempts to persuade their parents to stop smoking. These four participants were also some of the most vocal in their dislike of smoking in the focus groups and interviews they participated in, stating they "hated" smoking in the home and car, but mostly smoking per se because of the health risks to their parents and others. While perhaps not making a long-term change in family member smoking status, such persistence was perceived to be effective in the interim and rewarded by short-term quit attempts. Danielle D15 explains how she perceived her persistence to have been rewarded by her father giving up smoking for six months:

NRD: Have you ever talked to your parents about not smoking?

Danielle D15: Aye, I asked my dad [to stop] and he stopped for six months and then he started again.

NRD: Six months, wow. What was it like when he stopped?

Danielle D15: Aye, just not smoking and he used to moan at my mum for not smoking, for... to stop smoking and then she stopped smoking and then he started and then my mum started [smiling].

NRD: [laughter] OK, so why do you think they started again?

Danielle D15: [quietly] Don't know.

NRD: And why do you think ... so you think you asking them to stop made them stop?

Danielle D15: Aye, 'cause we kept on asking them for every week.

NRD: So can you take me through, like what did you used to say?

Danielle D15: He'd say, 'What,' and I'd say 'Stop smoking.' and he'd be like, 'Fine then,'... like everyday, 'Stop smoking.'

Others doubted their parents' ability to stop smoking because of the strength of their addiction and or lack of willpower. Jennifer A14, who gave a particularly resistant account, stated she would nevertheless persist attempting to make her mother quit: "*I don't think she will ever stop but I will keep **attempting** to make her stop*".

Most participants framed their motivation for resisting smoking solely as a concern for the person who smoked. Participants in one focus group in the advantaged area perceived it to be their responsibility, as a member of the family and someone close to the person who smokes, to attempt to make him or her stop smoking. The manner in which this request or concern was expressed was subject to some debate, however.

Anna A12: I do understand why people do it [smoke]. But shouldn't people around them, if people are trying to stop, shouldn't your people around you try and tell you it's bad for you?

Catriona A13: Yeah, to support them to stop but they don't need to be like really mean.

Anna A12: But if you do that then it'll give them more motivation to stop!

Here, whether the means justify the end is debated. Anna A12 argues for a more forceful approach because of its presumed efficacy, while Catriona A13 says she thinks such an approach unnecessarily harsh. Yet while reluctant to induce guilt in this manner when talking to Anna A12, Catriona A13 recounts the anger and frustration with her father's empty promises to stop smoking:

[Dad] goes 'I'll quit tomorrow', right? And then tomorrow comes and he says 'I said I'll quit tomorrow,' and then I'm like, 'But you said that yesterday, shut up,' and then I'm like 'Aaarghh' [laughter] ... so like, he bought these two massive packs and I was like [puts on angry voice] 'I'll kill you,' and then we put them in the bin and stuff [laughter].

As exemplified in this quote, while heated and an apparent source of family conflict, these interactions were nevertheless always recounted, and met, with laughter. The comic effect may be due to such accounts reversing the traditional and expected child/adult roles by positioning the parent as a misbehaving child being told off by their child assuming a parent role. Humour in this instance also appeared a way to defuse tension when telling tense stories. Role reversal of this kind was not considered possible by all participants, with some describing more traditional parent and child roles, further discussed in section 7.3. Catriona A13's account also demonstrates that overt and covert practices were not necessarily mutually exclusive or used in isolation. Instead, many children had a repertoire of strategies, used at different times or in different ways over time. Often, as in the quote above, asking parents to quit was an initial strategy, followed on by other covert strategies, as fully described later in this chapter.

Catriona A13 appears to distinguish between forcefully resisting smoking and "making people feel bad" or stigmatising people who smoke. The data produced and the dynamic within the group Catriona A13 and Anna A12 participated in highlight a further strategy of resistance: attempts to make those who smoke feel guilt and embarrassment. Aware of the moral discourses around smoking, some strategies of resistance employed by participants appeared to be unambiguous attempts to induce guilt or embarrassment and, in one focus group in the advantaged area, this went further into the territory of shaming and stigmatising those who smoke. While such shaming was not as explicit elsewhere, this focus group warrants a more detailed

exploration. Consisting of four girls from the advantaged area, it was one of two groups where most members did not have parents who smoked. Catriona A13 had a father and grandmother who smoked, Emma A12 had non-resident adult siblings and an uncle who smoked. Anna A12 had an uncle and a stepmother who smoked but she made particularly disparaging comments about her stepmother. Initially, the girls agree with each other about the risks of SHS and smoking but accounts start to diverge when they discussed strategies of resistance. Anna A12 assumed an accusatory role in the discussion, supported by Emma A12 and resisted by Catriona A13, who defended people who smoked in a number of ways, an interaction which perhaps co-produced particularly strong statements about people who smoke.

Emma A12: I just wrinkle my nose and turn away

Catriona A13: But that'll make them feel bad!

Anna A12: That's the point!

Emma A12: I don't want the smoke!

Here, Emma A12 justifies turning away from people who smoke by framing it as a protective strategy to avoid SHS exposure, yet her previous description of wrinkling her nose suggests she also intends to communicate her dislike of smoking. Further, she doesn't refute Anna A12's interpretation that the point of turning away from smokers is to make them "feel bad". Such actions were resisted by Catriona A13 who claimed they were unjustified when people smoked on the street and no harm would be done to those passing by, yet her contention was met by objections by the others who appeared to assume a "means justifying the ends" approach. Anna A12 in the group above made a number of particularly strong statements on this topic:

Anna A12: Last year I was outside Morrison's, that's like my second home, I go there constantly [laughter], and I had had all this Coke and sweets and I was like drunk

Emma A12: Drunk? [Looking at me]

Anna A12: and there was a gang of smokers and I was like, 'Smoking is sooo bad for you,' and then I like ran [laughing]. I felt so good that I had

said that.

NRD: Yeah? And what do you think that achieved, did it make them ...

Anna A12: It would make them feel embarrassed.

Running away and feeling proud suggests she perceived her action to have been a legitimate act of defiance. The increased stigmatisation of smokers, particularly in her advantaged community, was as strong when she talked about family members who smoked in her own family. In the following extract, she describes “making” her uncle smoke in the back garden rather than in the front garden as other people seeing her uncle smoking would stigmatise her by family association:

Anna A12: I make him smoke in the back garden because I don't want to be embarrassed like he was smoking in the street because that could give the street a bad reputation. And stuff like that, 'cause our street is really quite nice and it's in quite a nice area and there's no one who takes drugs or anything and that [him smoking] could put the market down and stuff. It's really embarrassing ...

NRD: It's embarrassing to you?

Anna A12: Yeah, for my next-door neighbours and friends in the street. They would probably think that in our family we would think it would be like ok, which I really wouldn't want people to think ... I just think it'd be really embarrassing if they're going to think you'd be able to smoke, it's such a disgusting thing, or they would think, like, 'She's been brought up in a place where they think it's alright to smoke, I don't want my children to be friends with her,' or something like that. And in our back garden we have really high hedges so people can't like see over...which is good [...] We have high hedges though, that's why I always make him smoke in the back garden so no one could see over and stuff like that.

As Anna A12 hypothesised about how “others” would perceive her family and herself because of her uncle’s smoking, she became a little agitated, raised her voice and stopped laughing and smiling as she had previously when discussing smoking in general. The stigma of a family members smoking and the negative effect this could potentially have on her and her area’s social status appeared to upset her. Emma A12 grew quiet at this point and looked a little uncomfortable while Catriona A13, again, resisted Anna A12’s statements, encapsulating her dislike of smoking, the

stigmatising of people who smoke in the following quote:

*Well, I ... I don't mind my Dad smoking even though I don't like it, but ... I think he should be allowed to smoke if he wants to smoke ... I don't think people should be like **judged** because they smoke.*

In this quote, Catriona A13 also appeals to individual rights. Such a discourse was briefly mentioned in a few other participants' accounts from the advantaged area but did not feature to any great extent.

Anna A12's and Emma A12's statements were not the only ones which touched on the perceived shame of smoking family members, but although there were suggestions of the use of stigma in many participants from the advantaged area's accounts, the intentional shaming of people who smoke was not a strong theme elsewhere. Participants often recounted instances where they delivered strong messages in a heated manner. At the time, I thought I was careful to avoid any responses, verbal or non-verbal, which would suggest disapproval of smoking or SHS. In retrospect, however, it is possible that some of the strength of these accounts were due to my expressed interest in acts of resistance that perhaps encouraged and legitimised such accounts. Given the discourse about "irresponsible parents who smoke around children", participants may have wished to present themselves as opposing such behaviours and thereby engaging in a similar discursive act of moral positioning as in their accounts of family members' responsible smoking practices, discussed in Chapter 6.

Given some participants' expressed purpose of making people who smoke feel guilty, and some mentioned that SHS aggravated symptoms of asthma, it is notable that so few mentioned capitalising on this as a strategy for resistance. The only instance was when Rebecca D14 told her grandmother she "couldn't breathe" when she smoked. Instead of using the potential and real effect family members smoking had on their own health, participants would talk about it as a reason that *parents* gave for smoking outdoors or wanting to quit, carefully positioning them as considerate and responsible smokers (see Chapter 6). For example, Ryan D14 and Anna A12 mentioned their non-smoking parent using child asthma to encourage outdoor

smoking. Ryan D14's mother asked uncles and other houseguests to smoke outside and Anna A12 mentions her mother uses her little sister's asthma as a justification for not allowing indoor smoking:

My uncle, he comes over quite a lot and I make him [go outside to smoke] and I'm just like, 'Can you please go outside?' and also my mum makes him go outside 'cause it's really bad for my sister's asthma.

Rather than using their asthma as an argument for stricter restrictions, participants extrapolated school health education information about smoking to attempt to make their parents and other family members quit smoking. According to the children participating in this study, SHS and its potential effects was not included in their school health education. It may be that abstract "official" information, such as school health information, is deemed more valid or possibly less emotive as a justification than personal experiences and feelings about being subjected to SHS. However, when comparing the accounts of children with asthma with those of other participants, those with asthma were among those who made the strongest statements about smoking and SHS, perhaps because they were the most affected.

Other overt practices of resistance were also employed, often in combination with verbal challenges. Such practices appeared to be about avoiding SHS exposure in an overt and demonstrative manner to induce feelings of guilt in the person who smoked by highlighting the effect it had on others. Such practices include coughing, moving away, rolling down windows in the car and in one case: fitting a smoke alarm. For example, Jennifer A14 from the advantaged area described rolling down all the windows in their car to escape the smoke:

In the car when she gets stressed by traffic she lights up... and I roll all, I roll the windows down and lean forward and cough and then she gets cold and angry and shouts [laughter], but I don't care, it's such an enclosed space I can't breathe otherwise.

On this occasion, the coughing referred to may have been a genuine effect of SHS exposure, yet on most occasions participants said purposively coughing when someone smoked was a strategy to to induce feelings of guilt:

NRD: And what does [your Dad] do when you were saying how you pretend to cough when he smokes, what does he do then?

Jack A11: He continues but ... he looks guilty [laughter].

Inventive and imaginative in his efforts to stop his father from smoking, Jack A11 also said he drew attention to the mess and dirt smoking creates, in this case, littering:

When we're in the car ... because he smokes out the window as well ... eh you know when he like flicks it out I go, 'Oh, litterbug, litterbug!!' and stuff like that [laughter].

Furthermore, Jack A11 and his non-smoking mother joined forces against his father's smoking by fitting a smoking alarm in the bathroom to dissuade his father from smoking there:

Jack A11: My Dad but always in the utility room by the back door. We make him [laughter]!

NRD: [laughter] you make him? How did you do that?

Jack A11: Yeah 'cause he used to smoke in the bathroom so we fitted a smoke alarm.

Colluding with a non-smoking parent to exert pressure on the smoking parent to quit or, as in this case, quit smoking around children, was also mentioned by a couple of other participants in the advantaged area and one in the disadvantaged area. In the disadvantaged area, most participants had either single parents or two parents who smoked, while in the advantaged area no participants had two parents who smoked. Fraser D11 said he asked his mother to ask his grandparents not to smoke around him. A non-smoking parent appeared to lend weight to participants' negotiation strategies by making them more radical and overt as in this example. Some participants in the disadvantaged area talked about colluding with siblings against smoking parents; this will be further discussed in the context of covert resistance in section 5.2; and while there is no suggestion in their accounts that this had a greater effect, colluding with non-smoking parents appeared to serve the purpose of

changing the smoking parent's practices. Child collusion with non-smoking parents was only mentioned by participants in the advantaged area, probably because most participants in the disadvantaged area had two parents who smoked.

Along with Rebecca D14, Jack A11 also said he would walk away from smokers. Rebecca said she would stand by the window if she could not, while Jack D11 clearly emphasised his own agency in this matter:

Jack A11: the only time I ever stand next to him when he's smoking is in the car and if I have to ask him a question when he's in the utility room, if something is wrong with the computer or something so he can help me or something.

NRD: But apart from that does he always smoke away from you?

Jack A11, 12: I move away [laughter].

NRD: You move away? How do you do that?

Jack A11, 12: Like when we were at a party at our neighbour's at his house and then they were all sitting round and I was there 'cause they only have one child and ... he's a bit older than me ... and we were just standing there and he [dad] started smoking and I was like, 'Well, maybe we can go up and watch a DVD or something.' But it's kind of difficult because my dad was smoking a lot and my neighbour I think 'cause he used to smoke it reminded him of smoking and I was like, 'What?? Doesn't matter, I'll go.'

Describing a social situation where he is frustrated both with his father's smoking and that another adult, his neighbor, sanctions his father's smoking and so the only option to avoid SHS is to go upstairs. Here, as elsewhere in the accounts, walking away was an overt but relatively mild act of resistance. As discussed in Chapter 4, several children in the disadvantaged area were asked to either leave the room when their parents smoked (Ryan D14, Robbie D10, Rachel, D13S, Lindsay D11) or move further away in the same room (Julia D11 and Amber D10). Yet the manner in which the participants talked about walking away off their own accord appeared to be more than just protecting themselves from SHS. Their dismissive tone of voice and facial expression were clearly indicating walking away was an overt act of disapproval of smoking.

7.3 Mediating risk information

Other verbal practices of resistance, equal in the strength of content if not in delivery to those just discussed, underscored the way in which participants acted as mediators of SHS and smoking risk information. Drawing on persuasive scare tactic health messages derived from school and media tobacco control campaigns, some participants said they selected the most repellent or memorable statements and passed these on to their smoking family members in the hope of persuading them to stop smoking. Two messages proved particularly popular to prompt repeating: that each cigarette cuts a certain amount of minutes off your life and the repulsive content of them.

NRD: Have you ever asked your sister not to smoke?

Melissa A12: Yeah I told her about how bad it is for you and she stopped for a while, and she like ... started again.

NRD: Yeah, and what did you tell her?

Melissa A12: After we got that talk in school [looking at the others in the group] I told her all the stuff that was in them and she stopped ... but she started again.

Catherine A13: We got told that every cigarette that you smoke takes away 11 minutes of your life, apparently.

Melissa A12; And there's sewage and stuff in them [pulling face].

Catherine A13: Yeah, I told my uncle that one. Didn't work! [laughter]

In this way, participants acted as mediators of scare messages which they used as a strategic device to dissuade adults from smoking. Scare tactics appeared to appeal to many of the children interviewed, for example two boys had this advice on how to stop people smoking: “*Scare them! [laughter]*” (Michael A12, Jack A11). Anna A12 said she always told her uncle “*you're going to die young [laughter]*”.

Evidently, overt practices are intended to communicate strong disapproval and distaste to induce guilt, embarrassment and fear in family members and others who

smoked. Participants drew on health education and the wider moral discourses around smoking parents to openly challenge people who smoke in clear representations of agency. These acts can be seen to illustrate their perceptions of their rights to express their views and to negotiate a smoke free environment and non-smoking “healthier” parents for themselves and also, perhaps, their wish to portray themselves as opposed to smoking to me, a tobacco researcher. In the next section, I will discuss resistant deeds of a different nature: those said to be committed in secret.

7.4 Covert acts of resistance

Abigail D12: I have hidden them and she asked me where they were and I was like ‘dunno’ [shrugs shoulders and smiles].

NRD: Have you done anything else?

Abigail D12: I’ve broken them. She asked me to go and get a fag from auntie [name] ‘cause she smokes too and I snapped it and then I was like, ‘Oh, it broke in my pocket.’ [laughter]

Abigail D12’s account exemplifies covert strategies of secretly hiding or destroying/disposing cigarettes which six other participants also described. Similar to the purpose of overt acts of defiance, covert deeds were also aimed at protecting their smoking family members’ health more than their own, with participants justifying their resistant practices around a concern for family members’ health. Conversely, a lack of concern for someone who smoked was linked to a lack of resistant practices in Anna A12’s statement that as she hated her stepmother she “*wouldn’t care if she got cancer*”. While extreme in its strength, this view still points to the same justification and logic in other participants’ accounts: if you care for someone you resist their smoking.

Unlike overt deeds, covert deeds were often mentioned in the context of attempts to avoid adverse consequences associated (or presumed to be associated) with overt deeds such as anger or punishment. In a trajectory of resistant practices, they often appeared to follow on from overt deeds. For example, Julia D11 stated that she and

her younger sister Amber D10 protested to protect their stepfather's health and themselves from losing another father (their biological father left when they were little). Hiding his packs of cigarettes underneath their little sister's cot-bed, she would replace them if she thought it might be discovered to avoid an angry reaction:

Julia D11: I hide them [cigarettes] when he's drunk.

NRD: Have you?

Julia D11: I hide them under my wee sister's bed, I have like 6 packs in there the now [smiling].

NRD: He doesn't know about it? Never discovered it?

Julia D11: Nah, 'cause I wait till he's away to the pub or drunk in the hoose or something and just don't tell him ... if he likes, says he's running out I'd just put them back before he got angry.

NRD: Have you always hid his cigarettes or is this a recent thing?

Julia D11: Nah it's just 'cause we're worried about him 'cause his my mum's fiancée, he's not my real dad and I dinnae want to lose a dad again ... just looking out for him.

NRD: And do you sometimes ask him to stop smoking?

Julia D11: [Nods]

It is difficult to tell whether the expected anger provoked by some acts of resistance was imagined or the result of previous experiences in this particular instance. However, other participants certainly described parents getting angry. Younger siblings also feature in Jennifer A14 and Robbie's D10 accounts in a different context, when they describe either encouraging younger siblings to covertly resist or pin the blame for covert acts on them. Jennifer A14 used a range of overt and covert strategies in combination to protest about her mother's smoking but mentions some are getting less acceptable as she is getting older.

Jennifer A14: This is going to sounds really bad but I shout at her. Quite a lot. And I snap her cigarettes, and I hide them. I've even poured water on

them once.

NRD: What happens then?

Jennifer A14: She goes, 'STOP that' and gets angry, too. I get into too much trouble now as I should know better at my age so I get my sister to do it, she's seven so she doesn't get into as much trouble for snapping cigarettes. I tell her where she keeps them and tell her to hide them.

Robbie D10 also reasoned that a younger sibling would not get into as much trouble, so could usefully be blamed for hiding cigarettes.

Robbie D10: I've hid a lot of cigarettes.

NRD: Have you? And did they find out?

Robbie D10: Yeah, I hid them in my Dad's boots.

NRD: In your Dad's boots! And what happened then?

Robbie D10: He went to put them on and he stood on them. I just said it was my sister. She doesn't get knocked about for anything.

Involving younger siblings in covert acts in order to avoid an adverse family member reaction, either by blaming them when discovered or encouraging them to participate, indicates the importance of age in acts of resistance. Covert acts are implied to be something less acceptable in older children, as Jennifer A14 is quoted above: she *'should know better at my age'*. Clearly, there are four years between these participants, so rather than an absolute age at which covert acts of resistance were not considered appropriate, it may be relative to being an older and younger sibling, but that is, of course, speculative, because of the lack of data. Interestingly, Robbie D10 mentions his overtly asking his parents to stop smoking as something that happened a long time ago, when he was seven. Perhaps resistance to smoking is considered childish per se by some participants. Younger children can perhaps "get away" with resistance exactly because their young age exempts them from social norms, reminiscent of research in other cultures, both recently (by Berman (2011) with Guatemalan children) and in Mead's classic work with children in New Guinea (2001(1930)). Ironically, this can lead to children's greater social impact (Berman,

2011).

Robbie D10 also mentioned the possibility of being hit by his parents twice in his account, which was clearly concerning.

NRD: They don't smoke when you're there. 'Cause they ask you to go away? Can you tell me a little bit more about that? How does that happen?

Robbie D10: [they say] 'Go up to play.'

NRD: Because they're going to smoke? And do you ever say, 'No I want to stay'?

Robbie D10: Sometimes.

NRD: And what do they do then?

Robbie D10: 'You're grounded.' Or hit me.

Disclosures about physical abuse clearly present ethical issues, particularly in research with children and young people and the way in which I dealt with this is discussed in detail in chapter 4.

While no other children talked about being hit, challenging parents on their smoking could prove difficult even to imagine for some participants because of either a child/parent hierarchy or an individual right to smoke discourse, both discussed in the next section in the context of an absence of resistance.

7.5 Accounts of acceptance and absence of concern

As shown in this chapter, many participants talked about their active roles and resistance when describing the nature of their family interactions around smoking and smoking restrictions. In some ways, the main focus of this study was the active roles of children, like other studies informed by a Childhood Studies perspective, and ways of resisting the power of adults clearly demonstrates child agency. However, 14 participants from both communities mentioned neither words nor deeds of resistance, of either an overt or covert nature. This section explores possible reasons

for their apparent lack of resistance or lack of expressed resistance.

Amongst those who expressed little resistance to family members' smoking were the six participants who smoked themselves. Accounts given by these participants differed from those given by others in more ways than this, as discussed in previous chapters. In Chapter 5, I discussed the way in which there appeared to be a lack of concern about their family members smoking and SHS in their accounts. While they did not disagree with the deeply held concern about smoking and SHS, they seldom expressed their agreement and never initiated such accounts. Again, as described in Chapter 6, some of the accounts of those who smoked themselves differed from others in that less, or no, smoking restrictions were reported in their homes. Smoking was allowed in all of their sitting rooms and they smoked in their own bedrooms. With regards to the resistant accounts examined in this chapter, these participants either said they did not engage in resistant practices or did so only minimally. For example, Jenna D15s said she would roll down the windows of her family's car should anyone smoke because of the confined space and, if they protested about the cold, would say "*dinnae smoke then!*". This protest was specific to the situation, however, Jenna D15s did not protest about smoking in the home but smoked there herself when her father was not present. It is of course possible that these participants had protested and resisted their family members' smoking prior to beginning to smoke themselves, like Rachel D13s. She describes the futility of this:

Nah [I don't ask my parents to stop], I've only told my mum to stop [in the past] and she does and then she's not and then she starts again. I don't think to be honest she'll ever stop.

Accounts from these participants therefore differed in many ways from those of others and it may be that concern about and opposition to a practice one is engaging in oneself may appear illogical to participants. While they did not appear uncomfortable discussing smoking in the home, they said less than others and some appeared a little disengaged at times, Like Thomas D15s who leaned back while others leaned forward and Jenna D15s who, halfway through the interview, asked how long it would last.

Such signs of disengagement, albeit very slight, characterised others' involvement in the study, too. Here I wish to clarify that I do not mean participants were disengaged, instead most appeared very interested in taking part in the study, in finding out more about others' views and collecting the data discussed in this and the preceding two chapters was an enjoyable experience. However, in relation to other participants, a few appeared less engaged and less keen to share their views and experiences of smoking in the home and car, and these included not only those who smoked themselves but also two participants in the disadvantaged area and two in the advantaged area. For instance, Alexa D10 did not appear to recognise Lindsay D11's concern about SHS but stated she just gets "*on with what I'm doing*". Erin D13 described a family where every member apart from her smoked and a home where smoking was permitted everywhere. She said little else in the group, which consisted of two other girls, Danielle D15 and Rachel D13s, who were close friends and whose banter, and later, bickering, domineered the group. To some extent, such apparent lack of concern could stem from the particular peer dynamics that represent both the strength and the flaw of the focus group method itself. Useful in prompting discussion regarding SHS and smoking practices with participants developing and challenging each other's accounts, in a way many seemed to enjoy, it can serve to encourage and nuance accounts. Exemplified in the extract below from Laura D12, Amy D12 and Victoria D12 where they discuss the rights of parents versus children, their individual views are stated and refuted in a more participant driven context as opposed to an individual interview (as discussed in Chapter 4). Equally, the peer environment can serve to silence some participants or certain accounts. The peer group context of a focus group or paired interview as discussed in Chapters 5 and 6 where the paired interview with Lauren A13 and Jessica A12 and the individual interview with Chloe A11, where chaperones were present in addition to myself throughout the interviews, which added a sense of surveillance. The girls appeared particularly uneasy and embarrassed when asked any questions relating to challenging family member authority such as asking parents to stop smoking and were silent or visibly embarrassed.

Other participants directed my analysis of the lack of resistance by describing a more traditional and asymmetrical power dynamic between parents and children

constraining resistance by making it futile, as evident in one focus group discussion with three girls from the disadvantaged area. While Victoria D12 and Laura D12 described a child and parent dynamic which negated child agency, Amy D12 challenged this view:

NRD: Do you ever ask your parents not to smoke?

Victoria D12: Well I didnae 'cause they don't!

Laura D12: It's like, I've done it but...

Victoria D12: Me too, once.

Laura D12: ... but you don't ask really 'cause your mum and dad they're like the boss of you, you're not the boss of them!

Victoria D12: You can say but they won't listen.

NRD: Do they not?

Victoria D12: Nah.

Amy D12: In my family people listen to children. And in my church they really want to know what we think, they always ask us. All the time.

NRD: And do you think children should be asked their opinions?

Amy D12: Yeah, 'cause children are the future.

[Victoria D12 and Laura D12 exchange looks]

Victoria D12: But you're the child, they're not supposed to dae what you say, you dae what they say.

NRD: What do you think [Laura D12]?

Laura D12: I agree with her [Victoria D12].

Amy D12: You could like cough or something!

NRD: Do you do that, cough or other things to show you're not happy?

Victoria D12: No, never done that.

Laura D12: It's your family; they're the boss of you.

NRD: Does that change the older you get or always stay the same do you think?

Laura D12: Well...

Victoria D12: They're always your parents.

Questioning the very idea of challenging their parents smoking on the grounds that it would not be their place to do so, Victoria D12 and Laura D12 firmly oppose the idea that adult behaviours or authority, at least within this area, could be subject to debate for children. In resisting this view, Amy D12 provokes even stronger statements from the other girls, prompting a discussion of their normative values and assumptions about the way in which parents and children are expected to interact. Nevertheless, both these girls say they have asked their parents to stop smoking “once”.

Grandparents who smoked were afforded a different status in children's accounts where children would refrain from challenging their smoking habits. Laura A13 was the only child in the advantaged area to have a grandmother who smoked but most children in the disadvantaged area had grandparents who smoked and, furthermore, would use them to exemplify particularly “heavy” smokers and their homes as particularly smoky. There is a suggestion of an intensification of the child/parent power hierarchy in accounts where challenging grandparents would be considered disrespectful and perhaps provoke an adverse reaction to a greater extent than asking parents would.

NRD: And what about grandparents, do any of them smoke?

Robbie D10: All of them.

NRD: What about when you go to their house, do they smoke inside?

Robbie D10: It's their house.

NRD: Yeah.

Robbie D10: But I never sit in the kitchen, living room ... I always get a row for just speaking when they're speaking!

NRD: they're quite strict are they? Would you ever ask them not to smoke?

Robbie D10: [shakes head]

NRD: Or not smoke around you?

Robbie D10: [shakes head]

NRD: And you know how I asked you about your parents before, have you ever asked them not to smoke?

[Robbie D10 nods]

NRD: Yeah? And what happened then?

Robbie D10: I said but they never stopped... Just kept daeing it.

Many spent prolonged time with their grandparents on a weekly or even more frequent basis, yet none of the children lived with their grandparents and this appears to explain their lack of resistance as in this account where Robbie D10 emphasises that "it's their house". Even in their own homes, participants did not challenge grandparents' smoking, to do so would be seen as a joke:

NRD: Do your grandparents smoke?

Rebecca D14: Aye.

Jenna D15s: My granddad did smoke and then he stopped...[to G2] you never knew my granddad eh?

NRD: So what happens when you go to their homes or they come to yours?

Rebecca D14: They get sent outside! [laughter, like a joke] Nah....

Later on, however, Rebecca D14 said she had challenged her grandmother's excessive smoking near her although her account of this suggests her act of resistance met was not particularly effective:

I hate going to my nana's 'cause my nana's a bad ... a heavy smoker and she like starts off a fag, puts it doon, blah,blah,blah, starts off a new one again and I'm like, 'Nan I can't breathe,' and she's like [puts on a high-pitched voice], 'I finished one about 20 minutes ago.' [laughter]

Stricter indoor smoking rules may, logically, lead to less resistance, as there would be less SHS exposure to resist. Three girls drew on this logic from the advantaged community, Lauren A13, Jessica A12 and Chloe A11 (interviewed on two separate occasions). They said they would be reluctant to say or do anything to resist their father's and older brother's smoking because they did not expose them to smoke so protesting would infringe on their individual, and possibly adult, rights.

NRD: So have you told him that you don't like him smoking ... ever?

Lauren A13: Nooo [laughter and looking at Jessica A12].

NRD: [laughter] No? Why not?

Lauren A13: Ehm ... 'cause it's what he wants to do. He always does it 'cause he wants to so I don't think I have the right to say.

NRD: OK, and is that because you want to be polite or... you know how you also said that when other people smoke you would never tell them not to – is that because you don't want to be rude or because it's not such a big deal or ... ?

[silence]

Lauren A13: People have a right to smoke ...

Jessica A12: ... if they want to.

NRD: People have a right to smoke if they want to.

Lauren A13: I feel embarrassed to say you know not to smoke...

There is no linear relationship between home smoking rules and strength of resistance evident in the data. Rather, participants who lived in smoke free homes also gave some of the strongest accounts of resistance. A more asymmetrical parent and child dynamic does appear to be related to accounts of less resistance. In the above extract, the rationale about less exposure is coupled with one where the individual right to smoke is prominent. These three participants in the advantaged area were the only ones who drew on individual, rather than necessarily adult, rights.

Apparent absence of resistance thus appears to be related to child smoking status, a more traditional child and parent dynamic, a discourse on individual rights to smoke, the focus group method and the interview context. Thus, accounts of resistance, rather than necessarily experiences thereof, may also be constrained by methods and contexts.

7.6 Conclusions

Demonstrating their agency in tales of resistance, most participants describe deeds and words intended to manage the risks entailed in smoking on behalf of their parents and other close family members. Encompassing a wide range of innovative and imaginative actions, from overt verbal protests to covert disposing of cigarettes, participants position themselves as autonomous mediators of risk between health education received in school and through the media and their smoking families. Assuming responsibility for reducing risks constructs a health-promoting identity, perhaps more akin to an adult parent identity, and another example of participants using accounts to construct their identities, as a “technology of the self” (Christensen and Mikkelsen, 2008). While I have divided resistant practices up and suggested there is a trajectory supported in many accounts from more overt practices leading on to covert and, for a few, acceptance, they overlap considerably in some accounts and some participants only engage in covert ones.

Agency of this kind is not evident in all accounts, and it is much constrained in others. A few say they do not mind SHS, most of whom smoked themselves. As noted above, the context in which the data were collected may have affected accounts of resistance, as well as those of acceptance. However much a few participants say they dislike it, they also claim they do not resist smoking in the home and car because of fear of adverse reactions. An adverse reaction, or a more general presumption of such a reaction of a child challenging a parent (or in particular, a grandparent, about their behaviour), was often highlighted in accounts as a turning point in encouraging less overt practices or indeed less resistance.

Practices of resistance are thus constrained by a traditional child/parent power hierarchy, one that could be negated most effectively by collusion with another non-smoking parent. Support from another adult family member which, with one exception, was only recounted in the advantaged area, was associated with some of the strongest and most visible or open acts of defiance, such as Jennifer A14's and Jack A11's accounts of shouting at their smoking parents and installing smoke

alarms. Older siblings also encourage and collude with younger siblings to overtly and covertly challenge parents' smoking.

This chapter has provided many examples of how the influence of other participants could act to encourage, constrain or silence accounts of resistance. Both resistant and accepting accounts may have been affected by the data collection context. Tales of resistance may be a means of pursuing an identity founded on increased autonomy from parents and/or be a response to the presence of a healthcare researcher who they may expect to be against smoking, conforming to a perceived anti-smoking "group-grid" (Douglas, 1985). Conversely, for participants who were more reluctant to share their experiences of resistance, it is also important to address what is at stake for participants talking to me (and chaperones on two occasions) about their parents' smoking and to what extent they felt disloyal doing so. Certainly, defensive discourses where children distinguished their parents from more irresponsible smokers were plentiful (and the subject of chapter 6).

Subtle distinctions are evident in the accounts of resistance given by participants from the advantaged and the disadvantaged community, illustrating different smoking "group-grids" (Douglas and Wildavsky, 1982). Stigma discourses were stronger in accounts from the advantaged community with the concern about what guests and neighbours would think in a place where smoking is not part and parcel of the risks encountered in everyday life if they detect signs of smoking, for example. A non-smoking norm (with non-smoking parents in particular) may legitimise participants' practices of resistance overall, and encourage more overt ones. However, as this and the previous two chapters illustrate, it is the extent to which children's strategies of resistance coincide that invites most discussion.

Accounts frame concerns for family members' health as underpinning such resistant practices. Evoking stigma by suggesting the person who smokes smells or is doing something to harm others speaks of how wider societal discourse about smoking and smokers are reflected in participants accounts.

Generally, however, parents were positioned as relatively unaffected by their

children's attempts at challenging their smoking. Vague postulations about parents perhaps "feeling guilty" or "getting angry" were made, but few actual situations were described. In providing accounts of their resistant practices, participants also present themselves as moral agents who protect their parents' health.

Like adult agency, child agency is not an undifferentiated force in shaping events. Rather, how effective it is depends on its relationship to social practices, structures and the capacities of the agent. Constraints are many on participants' power to affect smoking practices in their homes and cars and include child/adult power asymmetries which appear different in each family and also the social smoking norms of the community they live in. When such norms incorporate smoking, child agency appears more constrained.

While there is little evidence in these children's accounts that these acts were effective, other than in encouraging some short-term quit attempts, most participants recruited were recruited as children of parents who smoked, so if any of them had succeeded at making their parents quit they would have been excluded at the recruitment stage.

The resistance discourses participants draw upon when talking about family negotiations around smoking contrasts sharply with much previous research reviewed in Chapter 2, which implicitly positions children as passive victims of SHS. This may be because little research has been conducted with child participants, or because of the way in which children are positioned more generally. This chapter also shows how asking about tobacco can be a lens through which wider family health practices can be viewed, such as alcohol and physical abuse and family dynamics. It is with these two issues in mind that I move on the next and final chapter of this thesis.

Chapter 8: Discussion

8.1 Introduction

I have two objectives in this the concluding chapter. The first is to draw together the findings discussed in the preceding pages of this thesis about participants' accounts of their understandings, experiences and the nature and extent of their involvement in negotiating smoking restrictions in the home and car. Findings will be related to previous research, to demonstrate the contribution this study makes to the literature. The second objective is to consider the implications for future research, policy and health promotion practice aimed at reducing children's exposure to SHS in the home and car.

The chapter begins with a summary and discussion of the key findings within which the strengths and limitations of the study are highlighted. It proceeds to discuss the process of researching children's experiences and suggests fruitful avenues for further research. In the concluding section, the implications for policy and practice are discussed.

8.2 Discussion of findings

In exploring children's understandings and experiences of smoking in the home and car and the negotiations around these, this thesis explores an under-researched aspect from a group whose voices are seldom heard in tobacco control research so there is little directly related published research to situate the findings within. However, participants' accounts of risk, responsibility and resistance both confirm and contrast with previous research on smoking in the home with adult participants, particularly moral accounts and stigma (reviewed in Chapter 2) and child agency and voice (reviewed in Chapter 3). This

section will therefore first discuss how the themes of risk, responsibility and resistance interlink and how they relate to themes of morality and agency. It will proceed to discuss contributions to literature on researching with children.

8.2.1. Understandings of SHS

Like adult participants in previous research (Wardle et al, 2010), all participants were aware that SHS is considered a health risk. Unlike some adults in previous qualitative studies (Robinson and Kirkcaldy 2007ab), however, the participants never explicitly challenged or resisted to overall discourse of SHS risk. Framed as a “*health hazard*”, details of the magnitude and more precise effects it may have on health were missing from participants’ accounts however. Exhibiting none of the hesitancy that characterised their discussion regarding particular SHS risks and effects, the participants demonstrated a more detailed knowledge of scientific expert knowledge of how smoking posed a risk to cardiac and respiratory health. Bearing witness to their family members’ failed attempts to stop smoking, participants drew on discourses of physical addiction and coping with stress brought on by childcare and unemployment. Accounts of addiction and stressful life circumstances appeared to be presented to mitigate, or exonerate, parents and other family members from any blame that could be attached to their smoking. In contrast, accounts of SHS were seldom detailed or concrete but drew on the more familiar smoking risk discourse, so it was “*bad for your lungs*”. Some participants would state versions of the “passive smoking kills” message but hesitate or retract it when explored further. Instead, experiences of exposure were described in an embodied language of disgust, demonstrating their dislike of SHS. Importantly, many did not appear to consider SHS as posing any significant risk to their own health, at least not one that could not be managed by the responsible smoking practices they describe most of their family members engage in.

The need to protect those considered more vulnerable – very young children, those with asthma and pregnant women – from the risk of SHS was a script evident in all accounts of SHS, however. SHS risk was thus neither absolute nor all-inclusive in most accounts. Such certainty of the details of smoking compared to the uncertainty of precise SHS risks is likely to reflect the established and relatively recent health education messages that focused on smoking and SHS (a point also made by Martin et al, 2008).

Definitions of smokefree homes were not always homes free from smoke. Rather, smoking on the (ventilated) periphery of the house such as hallways and kitchens, were not always considered smoking in the home. This finding is supported in unpublished research with adults commissioned by the Department of Health (Fox, 2012) and has clear implications for future survey research. Surveys tend not to distinguish between central and peripheral spaces within homes, with potential misclassifications of non-smoking households as a consequence. In the disadvantaged area, a small number of participants stated their homes had no smoking restrictions but most said their parents only smoked in certain rooms or that they did not smoke near young children. The latter restriction reportedly sometimes involved asking children to leave the room while their parent(s) smoked, for children to return soon thereafter. In one case, children were reportedly asked to move further away but remain in the same room as the adult(s) who smoked. On the one hand, asking children to move away temporarily or within the same room suggests an awareness of the need to smoke away from children to protect them, but on the other hand, also a lack of awareness on how to protect children effectively. Clear differences are thus evident in accounts from the different communities suggesting different “group-grid” (Douglas and Wildavsky, 1982) norms for smoking practices. Protecting those considered vulnerable cuts across the grids but the ways in which this is achieved differs.

Smoking restrictions were often said to be subject to change over time, at different times of the day, in different spaces and for different people. Some participants reported that spatial restrictions may be relaxed temporarily, late at night, when guests visit, or when participants who smoke flout smoking restrictions in their own bedrooms (sometimes without their parents' knowledge). More often, however, participants reported firmer restrictions when individuals considered more vulnerable to SHS were present, such as children (albeit mainly babies and toddlers), pregnant women and children with asthma. In line with previous qualitative work (Phillips et al, 2007), accounts of home and car smoking restrictions are of a more fluid and nuanced nature than might be suggested by national survey data such as the most recent Scottish Health Survey (Bromley and Given, 2011).

Participants provided particularly strong statements of the experience of being exposed to smoking in the car. Using language that reflects their embodied experience of SHS of feeling as though they were choking and could not breathe, the confined nature of the car space made it a qualitatively different experience from SHS exposure in the home. Any protective attempts to disperse the smoke had the opposite effect with open windows making the smoke blow into the back seat where the children often sat. Further, almost half of the participants from both areas reported smoking occurring in the family car. This finding contradicts findings from a much larger and representative study which found much lower instances of smoking in the car for all participants and particularly for those from socioeconomically disadvantaged backgrounds (Akthar et al, 2007). As a small study with an imbalanced SES sample, no generalised claims can be made based on this finding, however.

Had the sample been larger and more diverse, suggestions of gender and age differences in the data may have also have been strengthened. Gender has been found to be an

important factor in negotiations around home smoking restrictions (Bottorff et al, 2005, 2006, 2009, 2010, Greaves et al, 2007, Robinson et al, 2010), yet it only emerged in a tangential way in the data from this study. A few participants said fathers were exempt from smoking restrictions or that their mothers smoked because of the stress associated with caring for children (as in Graham's classic study, 1987). Similarly, participants' age may have had implications for participant views and experiences had there been a greater variance, as suggested by participant accounts of the firmer smoking restrictions and less negative parental response to acts of resistance by younger siblings. That neither gender nor age emerged in the analysis in a more significant way may reflect a limitation of the sample. With just over three times as many participants from the disadvantaged area the sample was also socioeconomically skewed. However, given SHS is more prevalent in disadvantaged homes, the skew towards those from a disadvantaged background may have been beneficial in that this is where the issue of SHS exposure is most prevalent.

Despite such limitations, I would argue it is a sample of sufficient contrast and one that included a particularly under-researched group within SHS research. Generating data of sufficient depth to address the research questions, the study employed a Childhood Studies approach that asserts children are competent social actors in their own right, as opposed to merely adults in waiting. This focus on child agency again makes an important contribution to SHS research, a concept which this chapter now turns to examine further.

8.2.2. Agency and resistant accounts

At the end of Chapter 3, I referred to Adrian James' (2010) question about what another study demonstrating child agency would add, explaining I would answer that question at

this point. The presumed passivity of children within much SHS research may stem from the very young children focused on whose agency would be particularly constrained considering their inability to walk (away) or talk (back). However, the studies where children are mentioned in a more active sense tend to base this on parents' accounts of their children's active roles, rather than involve children themselves. When I started the fieldwork, I based my ideas on child agency in relation to parental smoking practices on Michell's interesting work that suggests children feel strongly and very negatively about being exposed to their parents' smoking (1989ab, 1990). The Liverpool study echoed this finding, if not as strongly (Woods et al, 2005). As yet, to my knowledge, there is no other published qualitative work on children's accounts of their views and experiences of smoking in the home and car or negotiations around home smoking restrictions. However, this thesis does not stop at declaring that participants exercise agency mainly in their resistance both to parents' smoking and to the prevailing public "irresponsible smoking parents" discourse. Instead, I have attempted to illustrate the nuances and constraints placed on participant agency in the themes of risk, parental responsibility and participant resistance and discuss the nature and impact of agency, how it is enacted, and to which extent.

Accounts are, of course, generated within a social context. Part of this context, as I have acknowledged throughout much of the thesis, is my own part in co-constructing accounts – in my choice of questions, response to answers and analysis. Komulainen (2007) has stressed that researchers should reflect on not simply what one hears but what one expects to hear. One of the explicit aims in this study was to examine children's roles in negotiating smoking restrictions and that, already, implies a reconceptualisation of children's roles from passive to active. On a few occasions I asked specifically about acts of resistance. For example, if a participant mentioned disliking SHS, I asked if they

had ever communicated that dislike to their family member in any way. My interest is likely to have encouraged tales of resistance more than perhaps ones of passivity or acceptance.

That said, data from this study throw new light on the role of children: describing acts of resistance, many participants present themselves (and sometimes their siblings and non-smoking parents) as actively attempting to negotiate smoking in their homes, albeit at times in a limited “one-off” way. However, there were also constraints placed on participants’ agency in child/parent power hierarchies. A key concept guiding the aims of this PhD is that “child” is a relational concept (Aries, 1972), that children are defined in relation to adults and that their worlds are, to a large extent, structured by adults. The experience of being a child and being an adult differs in a way that can be traced back to the interdependence of the relationship. In Mayall’s words, “the study of children’s lives is essentially the study of child-adult relations” (Mayall, 2002:27) because of the concrete effect the asymmetrical power relations between children and adults have on children’s everyday lives. Adults’ agency to shape their lives in the way they want is, of course, also constrained by their children. However, children’s agency is often constrained by adults to a greater extent because of children’s dependency on adults. Children are thus both vulnerable and competent (Komulainen, 2007), both passive and active, depending on the context. Participants’ agency does not preclude their vulnerability, either physically or in relation to their subordinated position to adults. More than their own health, most participants expressed concern for their smoking family members’ health. Providing compelling accounts of attempts to make parents stop smoking by nagging or shouting at them and snapping and hiding cigarettes, participants’ words and acts of resistance at times also involved younger siblings and, in the advantaged area, non-smoking parents. Such practices of resistance were not framed

as acts of self-care as much as protective of parents' health. Rather than managing SHS risk, many participants gave accounts suggesting they were attempting to mediate and inhibit the perceived risks their parents and other family members took in smoking, so managing risks on their behalf more than on their own. Resistant accounts challenge the implicit discourse of children as passive victims of SHS, but were seldom described as persisting over time. This might be because the accounts suggested resistance were mostly futile and had little effect and could cause tension and conflict in family relationships.

Participants' impact on home smoking practices appeared to be constrained by parents' greater power in the home and most parents were reported to resist attempts at negotiations from their children. Indeed, those resistant acts with most effect appeared to be those where participants were aided by non-smoking parents such as Jack A11's mother helping him to put in a smoke alarm in the bathroom, or Jennifer A14, whose non-smoking father will admonish her smoking mother in the presence of the children and so legitimise their acts of resistance. Collaborations between non-smoking parents and children or between siblings illustrate the interactive nature of agency: there is not just one agent. It remains that most participants in this study were subject to parent-imposed smoking restrictions, not ones that had been negotiated between equal partners.

This thesis also suggests child agency can intersect with socioeconomic advantage and disadvantage in relation to smoking practices in the home. While most participants from both areas found ways of subverting adult power in relation to smoking in the home and car, participants' agency from the disadvantaged area appeared more constrained with less available options or "thinned" in Klocker's terms (2007) because of a number of reasons. More of their family members smoked and there were fewer home smoking restrictions overall. A more permissive smoking norm with higher smoking prevalence

and fewer home smoking restrictions as in the disadvantaged community's 'group-grid' (Douglas and Wildavsky, 1982) appears to constrain participants' capacity to protest. The smaller homes in the disadvantaged area also meant that smoking inside almost always equals smoking in a family area, apart from when parents, siblings and participants smoked in their bedrooms. Unlike some participants in the advantaged area, the participants from the disadvantaged area did not have a non-smoking parent or wider group-grid norm to support them.

8.2.3. Responsibility and moral accounts

Chapters 6 and 7 of this thesis attend to the main data themes of responsibility and resistance. Such a categorisation belies the interrelationship of the themes. At first glance, participant accounts may even appear contradictory. Despite many describing their own deeds and words of resistance to family members' smoking, they also describe adult family members' smoking practices as responsible. Furthermore, they would sometimes change their accounts of smoking restrictions in their homes during the course of the paired interview or focus group. Rather than seeing such contradictions as challenging the validity of child accounts, conventionally seen as less reliable than adults', apparent contradictions can more usefully be understood in the context in which they are generated. Much of the analytic task therefore involved unpacking the apparent contradictions by acknowledging and attending to the situated and socially constructed nature of participants' accounts. As stated in the previous section, some participants would state that their homes were smokefree and then construct home floor plans where they verbally indicated that their parent(s) smoked in certain peripheral areas of the home, such as the kitchen, for example. Partly, this was to do with the idea that smoking in the kitchen was not the same as smoking in the house because of the ventilation and peripheral location of participants' kitchens. Yet initial accounts of smokefree homes

and, more importantly, that family members would never smoke near those considered vulnerable to SHS, such as babies, are underscored by a wish to frame parents (in particular) as responsible people who protect others.

This finding can also be seen to illustrate the differences between expert risk understandings received at school and through health promotion messages and situated and experiential understandings of risk in a different home culture. The challenge this may create for participants' face-work on behalf of their parents within the interview or focus group (Goffman, 1959) is actively (at least in part) resolved by casting parents as 'responsible' smokers. While participants did not challenge the scientific SHS risk discourse in their discussions, they re-cast parents from risk-takers to risk-avoiders through their practices to protect children and others vulnerable to SHS exposure. This finding supports a view of risk as being different across settings (Douglas and Wildavsky, 1982) and in different situations for the same individuals (Bloor, 1995).

Protection from risk was reciprocal in accounts. Participants attempted to protect their parents from the risk of smoking with their words and acts of resistance and parents often reportedly attempting to protect participants and other (particularly younger) children from the risk of SHS exposure. Parents were also said to control their smoking relative to others who smoked more cigarettes, more often and in closer proximity to others (by implication less responsible) people. This "other" is either not named or a more distant family member, such as a cousin, and serves as a downward comparison, or a "negative community of interest" in Douglas' words (1994), to the responsible smoking practices of parents in participant accounts. Defensive in nature, such statements reveal participant awareness that acknowledging that their parents and other adults smoke in their presence may present them as risk-takers which would pose a challenge their protective roles in the eyes of others. In this way, participants therefore

also protected their parents' moral identity in their accounts. Such defensive accounts are, I believe, resistant responses to a public discourse of parents who smoke as irresponsible. Arguably, portrayals of people who smoke, in particular parents, have almost descended to the level of caricature in public discourse (Graham, 2012, Bell et al, 2010), a public discourse participants appear to be aware of and attempt to resist.

Accordingly, it is important to consider what is at stake for children who talk about their parents and others smoking near them in a climate which increasingly stigmatises people who smoke (Ritchie et al, 2010, Graham, 2012, Bell et al, 2010). Many participants appeared to not just provide accounts *of* family members or their own smoking, but accounts *for* them. Participants resist negative moral interpretations of their family's smoking practices by using a responsibility discourse, listing the precautions they take not to put (vulnerable) others at risk. "Responsible" smoking practices mainly involved strategies of dispersal and distance. By distancing oneself from others when smoking and by dispersing the smoke, those who smoke were perceived as protecting others from any ill effects. Centring on responsibility of those who smoke to take protective measures, such accounts were imbued with morality and were often repeated throughout the interview. A discursive device used by participants was to position parents and other close family members as responsible through comparing their smoking practices with others who were said to take fewer, or indeed no, protective measures. "Responsible smoking" involved restricting smoking to the appropriate places: outdoors or in well-ventilated rooms, and distanced from vulnerable groups: very young or asthmatic children and pregnant women. Similar accounts of "responsible", or to use Blake Poland's term, "considerate" (2000), smoking are evident in those of how adult participants in other qualitative studies account for their smoking practices (Poland, 2000, Phillips et al, 2007), particularly mothers (Holdsworth and Robinson, 2008,

Robinson, and Kirkcaldy, 2007ab, Coxhead and Rhodes, 2006). Underpinning these narratives appears to be a concern with morality of not only oneself, but in this study, also family presentation. Findings in this study add to such findings by demonstrating how children can actively construct a competent and responsible familial (as opposed to just individual child) discourse.

Drawing on discourses around addiction, coping and stressful lives associated with understandings of smoking, participants also provided justifications of parents' smoking and ameliorated these with the control which their family members executed over their smoking, as discussed. Illustrating awareness of socioeconomic and structural factors impacting on individual and lifestyle behaviours, participants would see the links between stress and smoking, with stress linked to childcare and unemployment as also found by Rugkåsa et al (2001).

Participants accounting *for* parents smoking practices resemble and resonate with the way in which women accounted for men's smoking practices in Bottorff et al's study (2010). There are similarities in the power asymmetries implicit (at times explicit) in accounts between children and parents in this study and men and women in Bottorff et al's study (2010) regarding decision power in home and car smoking restrictions. Similar to many of the children in this study, some of the women in that study emphasised how men protected them and their children by never smoking around them, thereby ensuring children were not exposed to SHS (Bottorff et al, 2010). Bottorff et al's (2010) analysis of such accounts highlight the complicity of women in men's smoking practices but it may also be that women out of loyalty to their partners want to present them as responsible to preserve their moral identities as fathers protecting their children.

Participants in my study thus appeared to attempt to manage the impression of their family members in their accounts. This demonstrates how stigmatised smoking and smoking parents are becoming. The overarching theme that I would like to bring forward in this discussion is therefore that many participants apparently wish to present their parents – and themselves – as moral agents, and in so doing, resisting the stigma that is increasingly experienced by people who smoke (Ritchie et al, 2010). Many participants resisted stigmatisation of their family members who smoke. Accounts of resistance to their smoking appear to serve a purpose of presenting themselves as responsible agents who resist smoking and attempt to protect their parents' health, perhaps in the context of being interviewed by a health researcher, despite my attempts to build rapport and present myself as non-judgemental of people who smoke.

Stigma related to smoking played out differently in accounts from the advantaged and the disadvantaged community. In line with epidemiological evidence of socioeconomic differences in smoking prevalence, smoking was described as an anomaly by participants recruited in the advantaged area and as normative in the accounts from participants recruited from the disadvantaged area. Describing significantly fewer family members, friends and neighbours who smoked and significantly stricter smoking restrictions in the home, none of the participants from the advantaged area smoked themselves and appeared embarrassed to have family members who smoked. In US studies that analysed cross-sectional survey data on people who smoked and used to smoke in New York, stigma relating to smoking was reported more often by those of higher socioeconomic status (Stuber, Gale and Link, 2008) and Ritchie et al's (2010) study found a similar experience of stigmatisation in participants from both advantaged and disadvantaged communities. In this study it was some child participants from the advantaged community who provided the strongest statements of stigma by family

association. For example, Anna A12 talked about not wanting her uncle to smoke in the front garden in case it may affect her own social status. Instead of smoking in proximity to children, smoking *per se* was stigmatised in accounts from participants in this community. Recruitment was challenging, indeed, no participants initially volunteered the information that their parents or other family members smoked when others were present. In contrast, in the disadvantaged community, smoking was normalised, indeed six of the participants smoked themselves. Similar to accounts from the advantaged area, however, smoking around small children or in children's bedrooms was considered irresponsible. Community differences in the way smoking and smoking in the home and cars were perceived were evident in participant accounts and support previous findings about socioeconomic differences in smoking and smoking in the home (Akthar et al, 2009). A number of parents in the advantaged area were also reported to smoke inside their homes but in a utility room or study, for example, illustrating the different indoor options of protecting children from SHS that were not open to parents in the disadvantaged area who lived in homes without such extra spaces. In discussing where, when and in the presence of whom their family members smoke, participants in this study contribute to the understanding of smoking norms in the home and car and around children. While smoking in well-ventilated spaces such as the kitchen door appears an acceptable and socially sanctioned practice in both areas, smoking in children's bedrooms is particularly frowned upon. Smoking in the presence of small children is denormalised, even stigmatised, in most accounts.

Throughout this thesis, I have reflected on how different methods, my role, and participants' gatekeeper roles have shaped the data in different ways. In the following section I continue and extend these reflections by providing further discussion on the issue of child protection, power asymmetry and children's voices in child research.

8.3. Researching children's experiences

Alongside the more conventional qualitative methods of focus groups, paired and individual interviews, I used visual prompts including a novel home floor plans method developed within the study. Floor plans proved a particularly useful research tool, not only in the identification and documentation of temporal and spatial home smoking restrictions but also in prompting more concrete accounts of family negotiations regarding restrictions. The different methods used have highlighted the situated and contextual nature of participant accounts in that they vary with different methods. Talking to several participants at the same time as in the focus groups and paired interviews highlighted the different social smoking norms operating not only between different communities but within them. Consistencies and inconsistencies both between and within accounts, teasing and humour all contributed to a rich data set. Methods where child participants outnumber the adult researcher can help flatten (while not remove) the power hierarchy and I chose this approach in recognition of the generational divide between children and adults as an issue that adult researchers should acknowledge and attend to so that we do not unwittingly contribute to it in our approaches.

Yet as the process of this study has demonstrated, power is dynamic, and not something that can either be maintained by the researcher throughout the process, nor is it an item to be shared equally between researcher and participants or indeed between participants at all times. Attending to the circumstances in which different accounts were generated, I have examined the interaction, particularly between focus group participants, and the way it may have encouraged or silenced certain accounts. What remains unsaid and accounts that contradict others have also been attended to within my analysis and it is clear that the nature of group discussion can silence as well as empower participants.

In seeking to involve children as research participants and emphasising the importance of hearing and listening to the voices of children, I am joining a long line of researchers. However, this aim has been increasingly problematised (James, 2007, Komulainen, 2007). Just as the authenticity of children's perspectives have traditionally and conventionally been doubted, there is another equally unwise tendency to romanticise "children's voices" where the rhetoric around children's voices may seem like a "moral crusade" where the silenced and seldom heard are "given a voice" through the research process (Lewis, 2010). The Western mythologisation of children can lead to the authenticity of the words that emerge "out of the mouths of babes" being seen as more authentic somehow than accounts from adults when, in fact, the aspect of authenticity and representation is not different from social science research with adults (James, 2007). The context of the production and the particularity of those accounts need to be acknowledged. Rather than being seen as "the child's" perspectives of SHS in the home and car, it is these particular children's accounts of smoking in the home and car (just like a study of adults' perspectives would not be "the adult's" view). This does not mean the findings have no relevance to other children, but such relevance should no more be assumed here than with any small studies of adult perspectives. In our endeavour to promote the inclusion of children's perspectives in areas where these are often neglected such as SHS, it is important not to forget the generalisation of such research has the same limitations (and strengths) as other small-scale qualitative research.

Stating that children 'have a right to be heard on all matters concerning them', the legal and ethical rhetoric of Article 12 of the UN Convention of the Rights of the Child (1989) is commonly cited as a justification for research with children, and this study is no exception. Article 12 has, however, been critiqued for its ambiguity. Lee (2001:93-94)

highlights several caveats in the wording of the article; it only applies to children “capable” of forming their own views, and that their “age and maturity” should affect the way in which such views should be received by adults. Thus, this well-rehearsed argument of hearing and listening to children might only apply to certain children. Are “children’s voices” representative of the child participants in any particular sample or in fact the voices of those who are most articulate, vocal and/or those adults want to hear? The quotes I have selected are accurate recordings of what participants stated, yet mediated by their selection and interpretation and my own role in the research process has, of course, shaped it. Representation is a predicament in all research, and this study is no exception. I was aware that only hearing the most vocal and articulate children might be amplified with research methods involving more than one participant at a time that might silence some participants. I have carefully examined what was not said, which, at times, was as important as what was said. Following Lewis’ advice on noting (2010), contextualising, reflecting on and interpreting silence as well as voice, I have interwoven participants’ quotes and extracts of field notes of retractions, hesitance and silence. In my analysis, such instances have been attributed to the presence of gatekeepers, disagreeing or agreeing with peers, smoking status or the sensitivity of the topic. While words can be interpreted differently depending on the context, there is nevertheless an intended meaning, a discourse, as a more recognised point of departure for the analysis, and my analysis of participants’ silence is therefore more limited than that of their talk. In this thesis I have attempted to provide a nuanced account allowing for differences and heterogeneity not only between participants from different communities but also of different views and experiences. In doing so, I hope to represent my participants’ diverse, changing and conflicting views and experiences of SHS, rather than present a homogenous collective “child” voice.

Child protection concerns can conflict, even contradict, the ethos of research with children. I also contribute to the debate on children's voices in supporting recent calls for a more nuanced understanding of representation of children and their views in research. The theoretical shift in thinking about children with "ethical symmetry" (Christensen and Prout, 2002), discussed in Chapter 3, has held great sway over much social scientific research with children but less on wider society and child and youth organisations, perhaps. Rather, the process of gaining access to potential participants illustrated the tension between my aim to engage with children and young people as competent social actors with rights to autonomy, privacy and informed consent and the gatekeepers' wishes to protect children. Thus, my intention not to compromise participants' confidentiality at times appeared to conflict with organisations' child protection protocols. Such protective practices, while well intended, can potentially obstruct children's rights to informed consent and confidentiality. After this experience, I negotiated more privacy in another organisation, which led a third organisation to also ease their protocols. As discussed in chapters 4 to 7, these constraints can also negatively affect the interview atmosphere and thereby the data collected.

All research occurs in and is influenced by its social and cultural context. Clearly, the ethical framework evolves in the field and is, to some extent, context-specific and researchers need to negotiate local ethical protocols and practices and be sensitive to the demands placed on gatekeepers. Field relationships may need to be constantly renegotiated. Taking time to patiently build a rapport and trust with gatekeepers by addressing any concerns they may have, being attentive to issues which they raise, be prepared to provide references from departments heads and be prepared to compromise on less important issues, in short: provide reassurance but no compromises on the most important ethical safeguards such as confidentiality and informed consent. Such

interaction may help make such restrictions less restrictive for both researchers and participants (Heath, Charles, Crow and Wiles, 2007). An approach needs to be developed which is ethically appropriate and takes researchers, participants and gatekeepers' interests into account, for example, ensuring that the fieldwork encounter can be observed but not overheard to protect children's right to confidentiality and adopting cautionary practice (Masson, 2000). Although gatekeepers may feel they are acting in children's best interests by not allowing them to be interviewed in privacy, I would argue this also compromises their rights to confidentiality and compromises the quality of the data generated.

The conceptualisation of "the voices of children" risks neglecting the diversity of children's lives and experiences and instead portraying children as speaking with a voice with no reference to class or culture, a practice exemplified in Article 12 of the UNCRC, which speaks of the best interests of "*the* child" (as also pointed out by James, 2007). Indeed, in a recent UK study, the young people participating wanted to be treated "as individuals, not an age group" (Morgan 2005:183). Plows has also articulated the need to theorise childhood within understandings of child-adult relations and that these understandings will need to take account of the wider social, economic and cultural forces that shape those understandings.

In this study, I have attempted not to present a collective voice of (and thereby oversimplify) participants' experiences in all the data chapters. Rather, I have presented areas where their accounts converge and diverge both between and within communities. While I have aimed to make my interpretative frame as clear as possible, some misinterpretation may of course have occurred. For instance, some diversity of experiences and views, which I have suggested may be attributable to socioeconomic disadvantage or advantage and their own smoking status, may of course be, partly or

wholly, due to other factors of which I am (or indeed participants are) not aware.

8.4 Conclusions

In addressing children's views and experiences of SHS, this thesis contributes an under-researched perspective to smoking in the home and car research. Much of what participants said about risk, responsibility and stigma supports previous findings in studies with adults illustrating the danger, as noted by Corsaro (2011), in perceiving children as a different species, or as living in different worlds, when their cultures are heavily influenced by the adult cultures in which they live. Yet the perspective of children participating in this study also contributes unique contributions to increase understanding of what happens in homes where parents and other adults smoke with implications for policy and practice, discussed in detail in section 8.6. Challenging any assumptions about the passivity of children, the participants' accounts contain active resistance both to parents' (some to other family members smoking, but predominantly parents) smoking and to prevailing public discourses about irresponsible smoking parents. Few articulate, but many participants demonstrate, an awareness of the moral connotations in public discourses of parents who smoke. They engage with this discourse by detailing the many ways in which parents protect others by not smoking inside or not in the presence of children and so forth. Nearly all parents are said to attempt to protect their children in some way from SHS – often early in the research encounter and almost always without prompting- highlighting participants' awareness of the implicit, at times explicit, challenge to smoking parents' responsibility and consideration for their children.

There is an understandable concern with the asymmetrical power relationship between child participants and adult researchers in much methodological literature with less

attention given to asymmetries in other research relationships. Findings from this study illustrate that power relationships within research (as elsewhere) are dynamic and shift between gatekeepers, researchers, participants and between the participants themselves. For example, instead of empowering participants, focus groups containing a participant who was on the periphery, would often lead to that individual being silenced, highlighting the importance of the composition of groups (a point also made by Hight, 2003 in relation to paired interviews). With some exceptions (notably Heath et al, 2007), little has been written about gatekeepers, yet their role not only in accessing children but how that access is managed can be pivotal to the research process. In this study, their concerns about child protection led to some participants' rights to privacy and confidentiality being compromised, as discussed in Chapter 4.

This study has highlighted children and young people's accounts of their active roles in resisting parents and other family members smoking and contributed insights into our understanding of what happens in homes where parents smoke. Participants' reasoning around measures of distance and dispersal as protective measures, along with that regarding child agency and the complexity of interactions around smoking in the home and car, for both methodological and pragmatic reasons, are best captured using qualitative methods.

Despite most participants' self-presentation as active social actors who attempt to resist adults smoking, such tales of resistance also feature constraints on this agency that speak of the inherent asymmetry of power in the parent-child relationship. Parents decide smoking restrictions to a much greater extent than children do. Life circumstances also affect parents' agency in participant accounts, however. Drawing on public health discourses of addiction and smoking as a coping mechanism when stressed due to childcare and unemployment, for instance, participants also identify constraints on many

of their family members' wishes to stop smoking. Such discourses are similar to the ones of mothers in previous work who denied agency in their smoking because of addiction (Coxhead and Rhodes, 2006). It may be that parents have used these arguments in negotiations with their children.

8.5 Implications for future research

What this study presents is inevitably only one part of a complex picture. Addressing the perspectives of children begins to redress the balance in a field dominated by adult perspectives and parents' perspectives; this study represented a break from the need for adults to "validate" children's accounts. The child in SHS literature is vulnerable and passive, captive to its parent's decisions on smoking restrictions within the home and car, a framing of children that this study has challenged. Nevertheless, in a future study an intergenerational perspective of negotiations would further improve understanding of the creation and maintenance of smoking restrictions and power dynamics within families. Intergenerational perspectives would move beyond the dichotomy of studying parents or children and would provide improved insight into negotiations by, for example, examining fathers' and mothers' smoking practices from both children's and their own perspectives. Such a study could examine the dynamics of power within families including children's roles and any gender dimensions, thereby presenting a fuller picture of negotiations between parents and children and between children themselves. It would also add to understanding children's agency by obtaining parents' perspectives on the influence children have on their own practices regarding smoking and SHS. Families from different ethnic backgrounds, for example multi-generational Asian families could also contribute to understandings of family interactions. While ideally such a study would use observations rather than retrospective accounts of negotiations, it would be very challenging both ethically and pragmatically to achieve.

As previously mentioned, the next Scottish Health Survey will gather information on SHS exposure of children aged 0-15 for the first time (Scottish Government, 2012). It will include response options ranging from “people can smoke anywhere inside/in certain areas/outdoors” (Catherine Bromley, private correspondence, 2012). In light of the findings of this and other studies, future surveys could further specify areas within the home and include temporal restrictions such as smoking in the presence of children and in sitting rooms as opposed to more peripheral areas of the home such as kitchens and doorways. Future surveys with child respondents could also contain questions that recognise the active role and influence of children in negotiating family smoking practices and cessation attempts to give us a more detailed baseline.

Space and place clearly contribute in shaping family smoking practices in the home in this and other studies. Future research could also draw on the discipline of health geography to explore in more detail how community environments shape smoking practices in the home.² While there were only hints of gender shaping restrictions in this study, previous work clearly demonstrates the ways in which a gender lens can enrich analysis of smoking practices (Bottorff et al, 2006, 2010, Robinson et al, 2010). A future study could delve more deeply into the smoking practices of mothers and fathers and examine the gendered nature of home smoking restrictions decision-making in more detail, from the perspective of children and adults. Such studies could use a visual method to stimulate discussion such as home and community floor plans/maps and photography. Research into the establishment and maintenance of home and car smoking restrictions is also likely to benefit from a longitudinal design, capturing and contributing to understandings of changes in smoking restrictions over time (for example the arrival of a new baby, one partner quitting smoking, moving to a new house and the

² Canadian studies have used such an angle to examine smoking more generally but not how this applies to home space (Frohlich et al 2012, Holloway 1997, and valentine, 2011).

seasons).

In relation to socioeconomic differences in smoking prevalence and smoking practices within homes, an SHS study could examine which children are high priority (rather than high *risk* which, with its connotations of child protection, could stigmatise) for intervention and support. By including other ethnic groups of children, another important aspect could be examined. While the British white study sample in this study largely reflecting the ethnic composition of the communities they were recruited from, future qualitative research with children and young people from minority ethnic groups should be a priority considering smoking practices vary in different communities and are often more gendered with male smoking rates higher than female. Additional consideration could also be given to children with disabilities and different communication styles and how they negotiate smoking restrictions in their families. As the first study to take the perspective of children in the manner described, this study can also serve to develop a platform for comparisons with future studies adopting a similar approach in different locations, with children of different ages and different backgrounds.

8.6 Implications for policy and practice

Wider inferences about smoking restrictions in disadvantaged or advantaged groups are tenuous when drawn from a small qualitative study such as this one. Like most qualitative research, this study is more about theoretical rather than empirical generalisation (Mason, 2002:195) such as contributing to our understanding of what happens in homes where children live and adults smoke. Such a contribution can nevertheless be important in highlighting implications for policy and practice.

The SHS exposure of children in homes and cars has prompted calls for policy and legislative change suggestions. At the time of writing, the draft Tobacco Control Strategy for Scotland is under consultation (Scottish Government, 2012) (referred to as the Strategy from here on). Legislation against smoking in cars carrying children is seen as a step too far by some, for example a recent *Scotsman* editorial argued such a move would equal “state interference”, particularly as it may lead to attempts to legislate against smoking in the home (*Scotsman* editorial, October 16, 2012). Smoking in the home and in the car are two separate – if interlinked – issues. Smoking in the small, confined and semi-public car space is qualitatively different according to recent research showing levels of SHS in the car to be significantly higher (Semple et al, 2012), and according to the experiences of participants in this study. Proponents for such legislation include The British Medical Association, Royal College of Physicians, British Lung Foundation and ASH, none of which advocate legislation against smoking in the home. While the draft Strategy acknowledges the risk that SHS exposure entails for children in cars and homes, yet, similar to the other tobacco control areas of priority, in the Strategy there are no targets set to reduce it. The UK and Scottish Governments prefer an approach of persuasion rather than legislation, however, and while it is recognised as an important issue, there is no mention of future legislation in the Strategy (Scottish Government, 2012).

Instead, smoking advice and support are to be fully incorporated in public health nurses’ remit, and there will be a national social marketing campaign in 2013 raising awareness of SHS in enclosed spaces. Although health inequalities in smoking prevalence is mentioned and recognised elsewhere in the Strategy, the section relating to SHS does not mention it although disadvantaged homes are less likely to be smokefree (Akthar et al, 2009). The focus is on very young children, although baseline data on children’s

exposure to SHS will be gathered in the Scottish Health Survey for children aged 0-15 (A Tobacco Control Strategy for Scotland, draft 2012), there is no involvement of children to find solutions. In other parts of the Strategy, however, the importance of the direct involvement of young people is acknowledged: “Young people need to be given the opportunity to play an active role in tobacco control and policy makers and service providers need to listen to their views about what actions might be helpful to support young people not to smoke” (Scottish Government, 2012:12), and a Youth Commission on Smoking Prevention will be set up. Why not extend this to a Child Commission on SHS exposure or indeed, extend the remit of the Youth Commission to also look at SHS?

There is an understandable concern that informing children of the risk of SHS exposure might encourage them to bring those messages home, which might, in turn, cause tension within the family. And some of these words and deeds of resistance are indeed reported to cause friction between children and parents in this study. Rather than not providing information, however, opening up discussion in school health education about smoking in the home and car in a sensitive and non-stigmatising way should be explored in the way a few local initiatives are already doing in Scotland (see Chapter 2) and include this in the Curriculum for Excellence, which is aimed at all 3- to 18-year-olds in formal education in Scotland, including nursery. It aims to ensure that they develop the attributes, knowledge and skills to allow them to demonstrate four key capacities – to be successful learners, confident individuals, responsible citizens and effective contributors.

While the Strategy mentions the Curriculum for Excellence, it only does so in relation to prevention of smoking with young people. Informing children and young people about SHS which poses a risk to their health should be part of the Curriculum of Excellence, too. Using the empowerment model – now considered the main way in which health

promotion should be delivered (Green and Tonnes, 2012) – children could be supported to negotiate smoking restrictions in the home and car in a less confrontational manner which might help ease family tension and potentially raise awareness of more effective strategies to protect children from SHS.

Rhetorically, children’s voices can be powerful instruments in policy (King, 2004). Indeed, the images and voices of children have significant power, as Department of Health SHS media campaigns and local smokefree initiatives have found (Fox, 2012, Ridout, 2012). Recently, a Department of Health TV campaign in England (Fox, 2012) specifically targets the smoking practices that parents may consider protective, such as rolling down the car window or smoking in the kitchen door by saying: “If you could see the smoke, you would not smoke”, changing from a shot of smoke dispersing through the door to smoke filling spaces and reaching children. This campaign addresses the main gaps in SHS understandings identified in my study. In positive contrast to the prevailing discourse about irresponsible parents, particularly mothers, it counters the stigma by suggesting parents do use protective strategies, albeit ineffective ones, and if they knew how to protect their children effectively they would. However, it does not show what to do, just what not to do. Further, in focusing exclusively on babies and younger children, it could be seen to unintentionally reinforce the message that older children are not a concern.

A new local initiative in England has used signs in play parks in children’s writing saying “We thank you lots for not smoking in our play park” (Ridout, 2012). The latter approach was developed from research with people who smoke about the ways in which they would like such a message to be communicated in which they reportedly emphasised the importance of being asked politely (Ridout, 2012). This indicates that a more sensitive public health response is needed which distances itself from stigma.

Future health promotion campaigns such as the one planned for Scotland in 2013 (Scottish Government, 2012) and other initiatives should adopt this sensitive approach, emphasise assets and the importance of listening to children. While a deficit-based approach that highlights SHS risks and ineffective strategies to protect children is important, appeals to parents' responsibility imply that they are irresponsible and are likely to alienate parents who smoke and be counterproductive. An asset-based approach that highlights and builds on parents' current attempts to protect children from SHS is more ethical and may be more successful. A salutogenic or asset approach is based on a recognition that we need to sustain and improve good health in addition to identifying risk and preventing illness (Foot and Hopkins, 2012). Importantly, asset approaches do not provide an alternative to public services or the need to address structural causes of disadvantage, but instead, complements them (Burns, 2012). The American sociologist Aaron Antonovsky described "salutogenesis" as the process by which communities and individuals within them create health (1996). Focusing on salutogenesis rather than pathogenesis (causes of disease) should create and support health and refocus on how many people – despite their adverse circumstances – maintain health. Asset approaches are not new. Mentioned in different disciplines, mainly public health and nursing, since the 1980s, many health promotion initiatives already work with communities and individuals to involve, empower and build on their existing strengths. References to asset approaches have recently made it into many UK policy documents, including the most recent report on health in Scotland *Assets for Health* (2011).

Applied to SHS reduction, such an approach would – rather than just highlight what parents do wrong – identify and share the skills and resources already in existence in partnership with parents when attempting to reduce children's SHS exposure. Such an approach could explore how people in disadvantaged communities implement and

maintain home and car smoking restrictions to protect children and build upon them. Assuming and acknowledging existing protective practices present a different and more positive starting point to initiatives. Various local community initiatives exist in Scotland that involve with communities and people within them, including children, to reduce children's SHS exposure, although these have been neither evaluated nor rolled out yet. The most popular "pledge" approach may be seen to reward parents for changing smoking practices in providing silver and gold diplomas to be put on walls in the homes. The pledge interventions do not appear to have been evaluated so we do not yet know how effective they are and how the diplomas are perceived. The idea of giving adults diplomas to put on their walls appears a little condescending and parents and children's perceptions of these should be explored.

Parents' involvement and advice on what sort of initiatives would be helpful creating an active dialogue between service users and providers to build relationships and trust rather than inducements of guilt. The REFRESH study has shown parents appreciate a non-judgmental approach as well as visible evidence of a reduction of SHS in the home as a direct result of them altering smoking practices (Wilson et al, 2012). Prevailing public discourses about socioeconomically disadvantaged parents as irresponsible are counterproductive. While sometimes angry with their parents, many participants also expressed a fierce loyalty to their parents and families and made great attempts with their responsible smoking discourses to resist the prevailing public discourse about disadvantaged parents who smoke. The draft Strategy claims to be underpinned by an assets approach but one that is not currently evident in relation to the section on SHS within it (Scottish Government, 2012).

While there is a general acceptance and acknowledgement of SHS affecting child health, clear gaps in understanding of SHS remain and more information about specific effects

and, more importantly, effective protective strategies are required. Given the increasingly stigmatised status of smoking parents, clearly evident in official, public, media and participants' discourses, sensitivity is a must and any expression of distrust and doubt in parents' motivations to protect child health is unlikely to be helpful. Child SHS exposure is an important issue for public health that raises concerns, yet some of the ways in which this concern is expressed – equating SHS exposure with abuse or irresponsibility for example – is likely to be counterproductive. Such statements strike at the heart of the notion of parental responsibility and protection of child health – central to the parental role.

Within a wider context, combinations of different social, cultural and individual factors and circumstances generate distinct experiences for children from different communities. For example, a child in an advantaged area whose parent smokes will have some exposure to SHS but s/he is less likely to be exposed to SHS in family areas within the home, or by more than one person in the way that children in disadvantaged areas are. Suggesting there is a hierarchy of needs may not be helpful, but because of the anti-smoking social norms of advantaged areas, the larger houses and less prevalence, the needs of children whose parents' smoke who live in disadvantaged circumstances may need to be prioritised within a more universal strategy, addressing the needs of all children exposed to SHS.

Thus, there is a need for an asset-based approach which involves parents and children and distances itself from stigmatising parents who smoke; a discourse that children can be very sensitive, too, as demonstrated in this study where many appeared compelled to provide accounts that present their parents and other close family members as responsible smokers. The importance of children's roles within family interactions and negotiations around smoking in the home and car challenge the implicit discourse of

children as passive victims of SHS should be pursued in tobacco control practice and policy. School health education is one of the assets children in this study drew on to negotiate with their family members, pointing to schools potentially important role to play were SHS to be incorporated into the Curriculum of Excellence alongside the prevention of smoking.

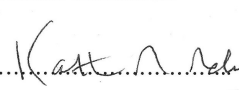
Appendices

Appendix 1: Ethical Approval

The University of Edinburgh
School of Health in Social Science

SCHOOL OF HEALTH IN SOCIAL SCIENCE

APPROVAL BY RESEARCH ETHICS COMMITTEE

Name/s of Researcher/s:	Amanda Amos
Proposed Title of Research:	Pilot study for 'Children and second hand smoke exposure in the home: a qualitative study'
Funding Body:	Chief Scientist Office
<p>The above research proposal has been approved by the School of Health in Social Science Research Ethics Committee.</p> <p>Signed:  (Kath M Melia)</p> <p>Date: 23-10-07</p>	

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Will any part of the research involve audio, film or video recording of individuals?	Yes With participants' consent, the focus groups and interviews will be audio-recorded. These recordings will only be accessible to the PhD student and her supervisors. They will be transcribed by the PhD student and used as a basis for analysis and for non-identifiable quotes in reports and presentations but for no other purpose.
Will the research require collection of personal information from any persons without their direct consent?	No
How will the confidentiality of data, including the identity of participants (whether specifically recruited for the research or not) be ensured?	The consent forms, the only documentation with participants' names, will be kept in a locked cabinet at the University of Edinburgh only accessible to the PhD student and her supervisors. When recordings are transcribed, participant names and other identifiable details such as other names and addresses will be changed. In all dissemination materials such as future presentations and journal articles, all identifiable details including area names will be kept confidential.
Who will be entitled to have access to the raw data?	The research team: Neneh Rowa-Dewar, Amanda Amos and Sarah Cunningham-Burley
How and where will the data be stored, in what format, and for how long?	Consent forms, recordings and hard copies of transcripts will be kept in a locked cabinet at Edinburgh University only accessible to the named researchers. Electronic copies will be kept in Neneh Rowa-Dewar's password protected University computer. All recordings will be destroyed at the end of the study and all other data at the end of writing up and dissemination of the PhD study.
What steps have been taken to ensure that only entitled persons will have access to the data?	All data will be kept in a locked cabinet at Edinburgh University only accessible to the named researchers. Electronic copies will be kept in Neneh Rowa-Dewar's password protected University computer.
How will the data be disposed of?	Recordings will be in a digital format so will be deleted. All other data will be destroyed using the PHS confidential waste disposal system.
How will the results of the research be used?	The results of this study will be reported in a PhD thesis, academic journal articles and conference and seminar presentations to researchers, policy makers and health promotion professionals. It is hoped that the

01.11.05

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3 RISKS TO, AND SAFETY OF, PARTICIPANTS	
Could the research induce any psychological stress or discomfort?	<p>Yes</p> <p>Although unlikely, it is possible that discussing parents smoking behaviour and home restrictions will be uncomfortable for some participants. However, it is not likely that discussing these topics will pose different risks from any other discussions participants may have with youth workers or teachers on health topics and several measures have been put into place to protect participants including:</p> <ul style="list-style-type: none"> • The PhD student is an experienced researcher with children and will, at any signs of potential discomfort, ask the participant if they would like to stop and if not, redirect the line of questioning or discussion. If distress is apparent, the researcher will not continue the data collection. • In the focus groups, care has been taken to phrase the questions in such a way that personal experiences in the home are not the direct focus to protect participants against over-disclosure in front of their peers. If participants wish to remain quiet it will be easy for them to do so. • A youth worker known to the children will also be present during the focus group to pick up on any signs of distress. • Participants will be clearly informed both in writing and verbally that they are free to stop the focus group and interview at any point.
Does the research involve any physically invasive or potentially physically harmful procedures?	No
Could this research adversely affect participants in any other way?	No
4 DATA PROTECTION	

01.11.05

Paper 05/RE/03

Will any part of the research involve audio, film or video recording of individuals?	Yes With participants' consent, the focus groups and interviews will be audio-recorded. These recordings will only be accessible to the PhD student and her supervisors. They will be transcribed by the PhD student and used as a basis for analysis and for non-identifiable quotes in reports and presentations but for no other purpose.
Will the research require collection of personal information from any persons without their direct consent?	No
How will the confidentiality of data, including the identity of participants (whether specifically recruited for the research or not) be ensured?	The consent forms, the only documentation with participants' names, will be kept in a locked cabinet at the University of Edinburgh only accessible to the PhD student and her supervisors. When recordings are transcribed, participant names and other identifiable details such as other names and addresses will be changed. In all dissemination materials such as future presentations and journal articles, all identifiable details including area names will be kept confidential.
Who will be entitled to have access to the raw data?	The research team: Neneh Rowa-Dewar, Amanda Amos and Sarah Cunningham-Burley
How and where will the data be stored, in what format, and for how long?	Consent forms, recordings and hard copies of transcripts will be kept in a locked cabinet at Edinburgh University only accessible to the named researchers. Electronic copies will be kept in Neneh Rowa-Dewar's password protected University computer. All recordings will be destroyed at the end of the study and all other data at the end of writing up and dissemination of the PhD study.
What steps have been taken to ensure that only entitled persons will have access to the data?	All data will be kept in a locked cabinet at Edinburgh University only accessible to the named researchers. Electronic copies will be kept in Neneh Rowa-Dewar's password protected University computer.
How will the data be disposed of?	Recordings will be in a digital format so will be deleted. All other data will be destroyed using the PHS confidential waste disposal system.
How will the results of the research be used?	The results of this study will be reported in a PhD thesis, academic journal articles and conference and seminar presentations to researchers, policy makers and health promotion professionals. It is hoped that the

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recruited?	who will mention the study to the children and ask if the PhD student can attend one of their regular meetings to explain in person what the study is about and give the children opportunities to ask questions. Children who are interested in participating will be given an information and consent form for the study (included in this application) to consider for a week . They will also be given an information and opt-out slip for parents to bring home. To ensure parents knowledge of the study, this information and opt-out slip will also be posted to them by the youth worker.
Will the study involve groups or individuals who are in custody or care, such as students at school, self help groups, residents of nursing home?	No (The study will involve participants in youth centre setting who are free to come and go as they wish.)
Will there be a control group?	No
What information will be provided to participants prior to their consent? (e.g. information leaflet, briefing session)	The PhD student can attend one of their regular meetings to explain in person what the study is about and give the children opportunities to ask questions. Children who are interested in participating will be given an information and consent form for the study (included in this application) to consider for a week.
Participants have a right to withdraw from the study at any time. Please tick to confirm that participants will be advised of their rights.	<input checked="" type="checkbox"/>
Will it be necessary for participants to take part in the study without their knowledge and consent? (e.g. covert observation of people in non-public places)	No
Where consent is obtained, what steps will be taken to ensure that a written record is maintained?	Participants will be given an information sheet with a consent form to sign which they will give to the youth worker or PhD student before data collection. This consent form will then be kept securely in a locked cabinet at the University of Edinburgh with access

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	only to the research team.
In the case of participants whose first language is not English, what arrangements are being made to ensure informed consent?	No special arrangements are perceived to be needed as only those children proficient in English will be recruited for pragmatic reasons.
Will participants receive any financial or other benefit from their participation?	Yes Participants will be given an individual £10 voucher for CDs or cinema, depending on their choice. This is now standard practice in research with these age groups, based on a recognition that young people have economical lives and rewarding them for their time is right. It is also what participants expect as some of them have taken part in previous research studies, all of which provided a similar benefit according to youth workers. Unless specifically asked, the PhD student will not disclose this benefit until the end of data collection, however.
Are any of the participants likely to be particularly vulnerable, such as elderly or disabled people, adults with incapacity, your own students, members of ethnic minorities, or in a professional or client relationship with the researcher?	No
Will any of the participants be under 16 years of age?	Yes Participants will be recruited from two age groups, 11/12 and 14/15 because these age groups are at key points of their own smoking transitions and little second-hand smoke research has been conducted with children despite the health risk to children it poses. Parents are given the option to opt their children out of the study because they are under the age of 16.
Do the researchers named above need to be cleared through the Disclosure/Enhanced Disclosure procedures?	Only Neneh who will be conducting the focus groups and interviews. Neneh's application is currently in progress but as she has current enhanced disclosure for her other place of work this should be speedy.
Will any of the participants be interviewed in situations	No

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which will compromise their ability to give informed consent, such as in prison, residential care, or the care of the local authority?	
6 EXTERNAL PROFESSIONAL BODIES	
Is the research proposal subject to scrutiny by any external body concerned with ethical approval?	No
If so, which body?	
Date approval sought	
Outcome, if known <i>or</i>	
Date outcome expected	
7 ISSUES ARISING FROM THE PROPOSAL	
<p>In my view, ethical issues have been satisfactorily addressed, OR</p> <p>In my view, the ethical issues listed below arise and the following steps are being taken to address them:</p> <ul style="list-style-type: none"> • Literacy issues: Some of the potential participants may have literacy issues, as already identified by the youth workers who work with them, therefore all the information in the information sheet will also be provided verbally. The activities in the focus group and the interview are designed to rely as little on literacy skills as possible, being talk and picture based. • Researchers becoming upset-There is a possibility that any qualitative data collection can be potentially upsetting to researchers because of the research relationship they build with participants. However, smoking in the home is not considered a particularly sensitive topic to research and the PhD student has considerable experience in researching cancer and cancer care, some of which with child participants of similar age groups, so is aware of the value of seeking support should there be a need to do so. Frequent and regular meetings with supervisors during the field work stage will be planned and the PhD student is an active member of several researcher groups where reflective practice takes place and support is available. The PhD student will also be accompanied by an experienced youth worker in the focus groups so there will be many opportunities to debrief with experienced supervisors and colleagues. 	

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<p>Signature <i>Amber Ames</i></p> <p>Date <i>22/10/07</i></p>
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8 Ethical consideration by School

The following section should be completed by the Head of School once the proposal has been considered by the School's research group.

I confirm that the proposal detailed above has received ethical approval from the School [* subject to approval by the external body named in section 6].

Signature

Date

* Delete as appropriate

Appendix 2: Parent Information Sheet and Opt-Out Form



Information for parents and carers 'Other people's cigarette smoke'



My name is Neneh and I am a student at the University of Edinburgh. I am doing a research study about what children and young people think about smoking, in particular other people's cigarette smoke. Although there is a lot of debate about 'passive smoking' or 'second hand smoke', we don't know very much about what children think.

Neneh Rowa-Dewar
0131 6513186
Neneh.Rowa-Dewar@ed.ac.uk

What do I want to talk to your child about?

If your child wants to, and it's OK with you, I am asking your child and other children the same age to talk to me in a small group or on their own if they prefer for about an hour about what they think about other people's smoke, and where people smoke in their communities and their homes. I will show them pictures of people smoking and ask them to talk about it. I am not going to tell them anything about smoking or give them any leaflets, just listen to their views.

Why?

I think it's important to listen to children and young people's views and we know very little about their views about other people's cigarette smoke. It's important that children and young people have their say.

When and where?

I shall talk to them at the Friday evening group at [group name]. I hope to do this next week.

Who will know what my child has said?

I would like to write what the children say in my report but I won't use their real name so nobody will know who said what outside of the group. If it's OK with all the children in the group I will be using a tape recorder so that I can listen carefully to everything afterwards and write it down. These are just for me to listen to and they will be stored safely in a locked cabinet at the University and I will only discuss what they say, without using names, with my supervisors. No one else will ever hear the tapes.

Does my child have to do this?

No, it's fine if they or you don't want them to take part. It won't make any difference to [organisation gatekeeper] or the other [people] at [group name]. Talk to your child about it if you want and contact me if you have any questions at all. I will keep checking that your child is happy to take part.

What happens after?

I'll send everyone who takes part a short report on what they and other children I've spoken to have said. I also have to write a thesis for the University and I would like to write articles that other people interested in my work could read.

OK- so what happens now?

If you are happy with this, I will ask your child to sign a consent form of their own if they want to take part. If you are not happy for them to take part, please let [gatekeeper name] at [group name] know on [organisation telephone number] within one week. If you want to talk to me about it or have any questions please call me on 0131 6513186 or email me neneh.rowa-dewar@ed.ac.uk or you can ask [organisation gatekeeper] to ask me to contact you.

Thanks!

Appendix 3: Participant Information Sheet and Consent Form



What do you think about other people's cigarette smoke?

Hi!
My name is Neneh and I am a student at the University of Edinburgh. I am doing a research study about what children and young people think about other people's cigarette smoke. Lots of children, young people and families live with people who smoke but we don't know much about your views. Can you tell me what you think?



Neneh Rowa-Dewar

Neneh.rowa-dewar@ed.ac.uk

What will we do and talk about?

If you want to take part, you would be with a small group or pair of other people your age that you know. We would talk together for about an hour during your usual time at [group name] next week. I'll show you some pictures of people smoking which we can talk about.

Here are some things we could talk about....

- **What you think about other people smoking**
- **The different places where people smoke and what you think about it**

If you want to talk with me on your own or with one friend, then that is fine - just let me know.

Why am I doing this study?

Children and young people have not been asked what they think about other people's smoke so we don't know what you think about it. It is important that children and young people have their say.

When? [day and date]

Where? [group]

Who will know what you have talked about?

Lots of people are interested in what young people think about other people's smoke so I would like to use some of the things that you say in my report. But I promise I won't use your or your friends' real names so nobody will know who said what outside of the group. If you want to tell your parents or anyone else what you said then you can do so but it's really important that you don't tell anyone else what the others in the group said.

If it's OK with you, I will be using a tape recorder so that I can listen carefully to everything afterwards and write it down. I will ask you if there's anything you said that you don't want me to write in my report. I will talk about what you said with my supervisors but I won't use your names. No one else outside the research team will ever hear the tapes.

Do I have to take part?

No, it's fine if you don't want to and it won't make any difference to the [group] or any of the people who work there. You can talk to your family and friends about taking part before you decide and you can ask me anything about the project before you make up your mind. You can change your mind about taking part at anytime during the project too.

What happens after?

If you want, you will get a short report on what you, other children and young people I'm speaking to have said. I also have to write a long report for the

University and I would like to write articles that other people interested in my work could read.

Do you want to take part?

If you want to take part then give your parent/carer their information sheet and me your completed consent form next week. If you have any questions or would like to talk to me about it more you can call me on 0131 6513186 or send an email to neneh.rowa-dewar@ed.ac.uk.

Consent Form

My name is , I am happy to take part in the 'Other people's cigarette smoke' study.

My address is

.....

My signature.....

Date.....

Please give this to me next week.

Thanks!

Neneh Rowa-Dewar, Public Health Sciences, University of Edinburgh, Edinburgh.

This study is funded by the Scottish Government Chief Scientist Office and supervised by Professor Amanda Amos and Professor Sarah Cunningham-Burley.

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